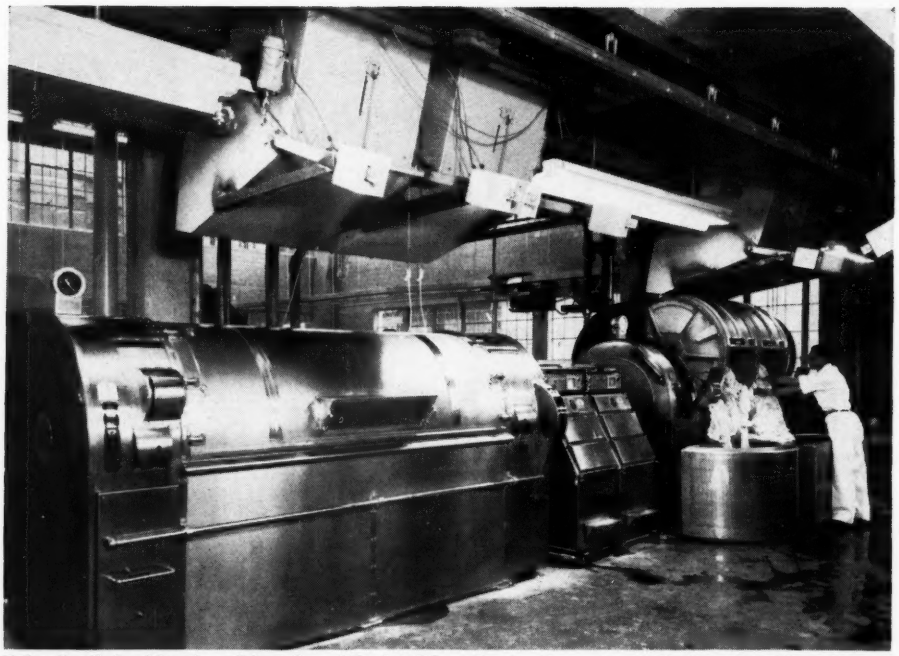
March, 1956

Canadian Hospital

- *The functional role of the hospital*
- *A symposium — "The hospital in tomorrow's world"*
- *Hospital finance under government-sponsored hospital insurance*
- *In preparation for a national health service*

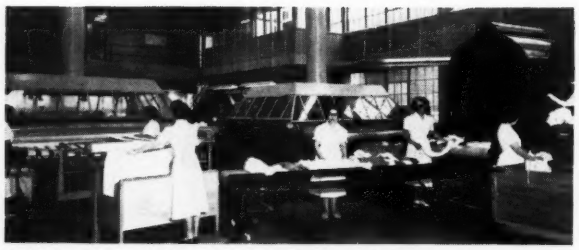
Canadian Hospital Association



All-Canadian-Equipped Laundry at Calgary General Hospital, Calgary, Canada. From the beginning, Canadian planned complete installation for maximum automatic operation. Convenient hoppers receive soiled work, which is dropped through chutes from floors above directly into washers. Fully automatic controls (center) operate two Cascade Unloading Washers, one shown emptying load into containers for Notrux Extractor.

Canadian planning helps Calgary create . . .

One of the Continent's most modern hospital laundries



Mechanized Flatwork Ironing. Operator at far right places extracted work on inclined Feed Conveyor to Rotaire Continuous Conditioning Tumbler. Next operator lays conditioned large pieces on another conveyor which takes work to Sager Spreader. Mechanically opened up and smoothed out by the Spreader, linens are delivered directly to feeders at 8-Roll Super Sylon Ironer which is equipped with Trumatic Automatic Folder.

Conveyorized Press Department. Uniforms for nurses and staff are completely machine-finished on these three single-operator Super-Zarmo, Super-Zarmoette Press Units. Overhead rail conveyor takes finished garments from the press units, and a belt conveyor takes all finished work from the laundry down to the Linen Sorting Room in the basement. Laundry is of efficient mezzanine design, with tile walls and most modern ventilating equipment.

Over 22½ Tons of Work Weekly, including uniforms and other garments for large staff, nurses and students, are processed by Canadian-planned laundry of 550-bed Calgary General Hospital. Modernization and mechanization of the laundry reduced costs, saved labor, supplies and water. Linens are also returned to service on faster schedule, and working conditions in the laundry are greatly improved.

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Contents

Vol. 33 · March, 1956 · No. 3

(For Subscription Rates, see page 106)

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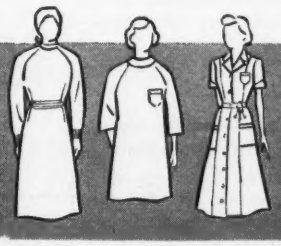

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◂ Notes About People ▸

Gordon L. Pickering, a director, Canadian Hospital Association

(This is the ninth of a series of biographical notes, introducing officers and directors of the Canadian Hospital Association for 1955-57.)

Gordon L. Pickering was born at Fort Langley, B.C., in 1913. When he was four years old, his family moved to Wilcox, Sask. In pursuit of education his steps led successively from the small rural school to Campion College, Regina, and then to the University of Manitoba where he was granted an Arts degree in 1935 and a Bachelor of Science degree in accounting in 1937.

Gordon Pickering started his hospital career as accountant with the Grey Nuns' Hospital in Regina from 1938 to 1941. He served with the R.C.A.F. from 1941 to 1945 when he became accountant with the Holy Cross Hospital, Calgary, Alta. Following two years as cost accountant with Associated Textiles of Canada at Louiseville, Que., he was appointed to his present position of comptroller of St. Boniface Hospital in 1949.

Since moving to Manitoba he has been active in the affairs of the provincial hospital association. Since 1950 he has been a member of the board of trustees of the Manitoba Hospital Service Association; president of the Associated Hospitals of Manitoba, 1954-1955; member of the Advisory Health Commission of Manitoba, 1955; and a member of the Statutory Rate Board, 1955. In addition, Mr. Pickering found time to complete successfully the C.H.A. extension course in hospital organization and management. At the biennial meeting of the Canadian Hospital Association held in Ottawa, May, 1955, he was elected to the board of directors and, at a subsequent meeting of the directors, was named chairman of the committee on constitution.

Gordon L. Pickering

Mr. Pickering's year as president of the Associated Hospitals of Manitoba proved to be a very busy one for him. Lengthy negotiations with the government of Manitoba were in progress and this entailed many long meetings. During the period of his leadership, agreement was reached whereby the financial stability of the individual hospitals of the province was markedly improved through a satisfactory solution to the long-standing problem of financing indigent patient care. *(See "Canadian Hospital", February, 1956, page 42.)*

* * * *

New Director of Nurses to take Special Course

Elizabeth Summers, R.N., B.N., has been appointed director of nurses at St. John's General Hospital, St. John's, Nfld., succeeding Mrs. Phyllis Barrett. She will take over her new duties late this year. Miss Summers received her R.N. at Halifax Infirmary, Halifax, N.S., and after three years with the Royal Canadian Navy obtained her Bachelor of Nursing degree at McGill University, Montreal. At present she is with the Department of Health, Newfoundland, as associate director of nursing services. Before starting her new work, Miss Summers will take a post-graduate course in nursing administration at the University of Washington, Seattle, Wash.

* * * *

Regional Hospital Council, Sask., Makes New Appointments

C. J. A. Sloan has been appointed regional accountant to the Regional Hospital Council, Swift Current, Sask. Mr. Sloan was formerly assistant accountant at The Hospital for Sick Children, Toronto. Harry Heaton, R.T., left his post at the Moose Jaw Union Hospital to become supervising x-ray technician for the council. Miss L. Gordon has also accepted a position with the council as dietitian. She previously held the post of nutritionist on the Assiniboia-Gravelbourg Regional Health Board, also in Saskatchewan.

* * * *

Gladys Lehigh Accepts New Post

Gladys Lehigh, Reg. N., has been appointed superintendent of Stevenson Memorial Hospital, Alliston, Ont. Miss Lehigh received her training at Ross Memorial Hospital in Lindsay, Ont., and subsequently joined the staff, eventually becoming assistant supervisor. She then accepted the position of night supervisor at Port Hope Hospital, Port Hope, Ont., and within nine years became superintendent of that hospital, which she has left to take up her present appointment. Miss Lehigh is a native of Picton, Ont.

* * * *

Three Doctors Honoured by University of Manitoba

Honorary degrees were conferred recently on three well known men in the medical field by the University of Manitoba, Winnipeg. Dr. G. D. W. Cameron, deputy minister of national health and welfare, Dr. A. F. Menzies, physician and surgeon from Morden, Man., and Dr. R. B. Mitchell, author of *Medicine in Manitoba* and former professor of obstetrics, each received the degree of Doctor of Laws in recognition of their contributions to the field of medicine.

* * * *

Toronto Doctor Honoured by Patients

A gift fund of over $7,000 was presented recently to Dr. Marion Hilliard, chief of obstetrics and gynaecology at Women's College Hospital, Toronto, as a token of appreciation from a group of the doctor's former patients. Mrs. Lester B. Pearson, wife of Canada's Minister of External Affairs, made the presentation at a party sponsored by the hospital's auxiliary. The Marion Hilliard Fund is to be used for any medical purpose of Dr. Hilliard's choice.

* * * *

New Superintendent at Chesley, Ont.

Mrs. Lenora Stubbs has been appointed superintendent of Chesley and District Memorial Hospital, Chesley,

(Concluded on page 16)

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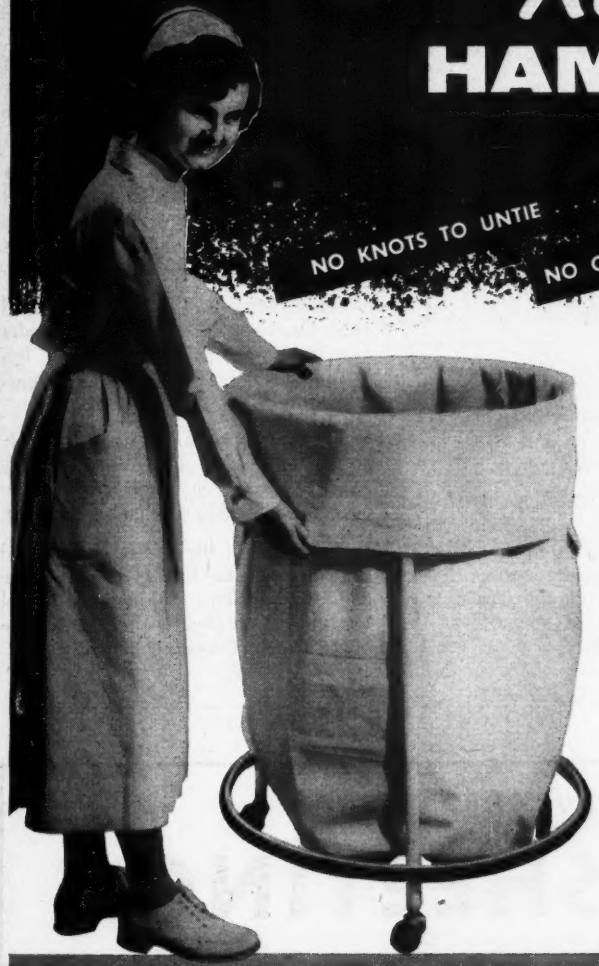
NO KNOTS TO UNTIE · NO GROMMETS TO TEAR LOOSE · NO ACCIDENTAL SPILLING



Draw-string laundry bags are costing you hundreds of dollars every year in repair work and in time lost tying and untying knots, untangling ropes from the wash wheel and dryer, and in picking up wash that has spilled out because of insecure knots.

The new Self Closing Ropeless Bags eliminate all of these time and money wasting problems and provide a *safety factor* in the elimination of possible *casualties* with ropes in the Mental and Nervous Disorder sections of hospitals.

This convenient, uniquely designed bag closes and empties faster than a draw-string bag. Made to fit your hamper stand, these sturdy bags have been tested and proved to withstand long, hard usage.

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Notes About People

(Concluded from page 12)

Ont., succeeding Helen Marshall who recently resigned. As a nurse, Mrs. Stubbs has worked in many hospitals in the United States and Canada. After taking a course in hospital administration at Columbia University, New York City, she then became supervisor of nursing aides at the Kitchener-Waterloo Hospital, Kitchener, Ont., before accepting her present position.

• Joan Groves was recently appointed a nutrition consultant with the Department of Health and Welfare in British Columbia. A graduate of the Ontario Agricultural College, Guelph, Ont., and the University of British Columbia, Vancouver, B.C., Miss Groves has had experience in hospital dietetics in Ontario and British Columbia.

• R. C. Dixon has been re-elected chairman of the board of Highland View Hospital, Amherst, N.S. This will be Mr. Dixon's sixth term on the board.

• J. H. D. Hargrave, representing Tadanac on the Trail-Tadanac Hospital board, Trail, B.C., was re-elected chairman of the board at the annual meeting recently.

• Mary Angus has accepted the post of Emergency Feeding Officer, Welfare Services, Civil Defence Division, Department of National Health and Welfare, Ottawa. Miss Angus has had dietetic experience in several parts of Canada, the United States, and Europe.

• Dr. John Stewart Manchester recently took up a post with Victoria General Hospital, Halifax, N.S., as head of the radiology department. He has also been appointed a professor of radiology at Dalhousie University, Halifax. Dr. Manchester is a native of Saint John, N.B.

• Monique Saint-Hilaire has left her position with the biology department at Laval University, Quebec, P.Q., to take up a post with Nutrition Services, Maternal and Child Health Division, Department of Health and Social Services, New Brunswick.

• Paul D. Shannon, C.A., controller of the Royal Victoria Hospital, Montreal, P.Q., recently spent a week in Houston, Texas, giving a series of lectures to members of the Texas Hospital Association and students at the University of Texas.

• A. H. McPhail has been named chairman of the board of Victoria Hospital, Renfrew, Ont. Mr. McPhail has been a member of the board for 35 years and succeeds H. H. Dymond.

• Dr. J. A. Matheson, Gull Lake, Sask., has accepted the position of medical administrator of Moose Jaw Union Hospital, Moose Jaw, Sask. He took up his new work in February.

• Jessie Stanford, R.N., has been appointed matron of Cardston Municipal Hospital, Cardston, Alta. She succeeds Mrs. Melvin McConochie who has resigned after eight years of service.

• Peter Miskew has been named chairman of the Royal Alexandra Hospital's board of trustees, Edmonton, Alta. This is Mr. Miskew's second term in this capacity.

• G. W. Dawson was recently elected president of the board of the Hôtel Dieu de St. Joseph, Chatham, N.B. He succeeds Michael J. Leggatt.

• Stewart G. Reid was re-elected chairman of the board of Restiouche and Bay Chaleur Soldiers' Memorial Hospital, Campbellton, N.B., at the board's annual meeting recently.

Twenty Years Ago

("The Canadian Hospital", Mar., 1936)

"Television is here but is not yet applied to hospitals", according to an article on *Recent Developments in Hospital Construction and Equipment*. "For any complete system of radio equipment", the article continued, "it should be remembered that reasonably perfected television broadcasts will be available eventually. However, it may be some years before it becomes popular enough to warrant the installation of relay systems for distribution. Television reception requires two distribution systems, one for sound and one for vision. For this reason, if the installation of television service is considered for some future date, it is desirable that the special circuits be included in new building schemes or, at least, that conduits to take the wiring should be built in to avoid subsequent damage to the building".

Here are some suggestions, by superintendents and department heads, on "sound practice" in the building and operation of your hospital. It is sound practice not to allow architects, in their desire to create an effect of spaciousness and grandeur, to burden forever your hospital with upkeep costs upon unnecessarily large corridors, service rooms, diet kitchens, utility rooms, public rest rooms, and other non-revenue-producing units. Do not use ordinary single thickness window glass but consider the use of the double glass now on the market which adds greatly to the insulating properties of your building, as the heat loss through glass is very high. Don't be too liberal with your baths and toilets. Comparatively few are needed. By the time a patient can use one he is generally about ready to go home.

In the kitchen it is sound practice not to use small ceramic tile on the floor. Grease and heavy food carts break tiles and make them come loose. Do not plan a kitchen without an adequate fish and poultry preparation room, equipped with deep wash sinks and separate chopping block. The preparation of these two foods causes considerable mess and odour which is best kept out of the kitchen or meat room. Keep in mind that grease attacks galvanized iron. Stainless steel sinks last longer and look better.

Because of their location, some hospitals are confronted with a serious problem of outside noise. "While just what degree of noise interferes with a patient's progress is a controversial subject," says W. Mezger, superintendent, Knickerbocker Hospital, New York City, "nevertheless we can agree, I believe, that street noises, particularly in congested areas, can exercise a disturbing influence. The shutting out of noises usually interferes with ventilation. To meet this condition there is available a unit which can be easily installed in the window. By means of an electrically operated fan, air is admitted in any desired volume up to the capacity of the machine and passes through an efficient filter. Noise is eliminated through a baffle and the effect is the same as though the window were closed".

"The principle of hospital architecture is a constant submission to medical science, sociology and customs, and represents continuous progress", according to B. Evan Parry, F.R.A.I.C., in an article on modern trends in hospital architecture. Mr. Parry is of the opinion that, "If we build a new hospital let us learn to express current thought and not necessarily repeat what others have said before. It has been for some time evident that the problem of the hospital must be reconsidered and resolved, for the hospital of the past appears to us today as being inadequate, impractical and unsuitable".

Nothing will ever be attempted if all possible objections must be first overcome. — *Dr. Samuel Johnson.*

W. Douglas Piercey, M.D., Editor

The Canadian Hospital

Obiter Dicta

The Hospital in Tomorrow's World

IN THIS issue of *The Canadian Hospital* we are pleased to be able to publish a series of articles by international authorities in the field of health and patient care. These are based upon addresses delivered at the formal opening of the University Hospital, Saskatoon, May 14, 1955, and at a special convocation of the University of Saskatchewan on the same day, as part of the opening exercises. In the audience on that auspicious occasion were students who, in 1957, will be the University of Saskatchewan's first graduates in medicine, the opening of the new hospital being essential to the establishment of a full program of medical education in that province.

The determination to achieve this program originated in 1942 when it seemed that a national program of health insurance was imminent and there was need for many more physicians in this country. Saskatchewan was particularly short because students who travelled to other universities to study medicine did not always return, especially to rural areas. The project was delayed during the war years for a variety of reasons but its urgency was emphasized with the launching of the Saskatchewan Hospital Services Plan in 1947. Its completion, in the opening of the University Hospital, happily coincided with celebrations of the fiftieth anniversary of Saskatchewan, as a province, and the graduation of its first medical students may well coincide with the establishment of a national program of hospital insurance.

In our September issue, 1955, we featured six articles which portrayed some of the essential units of the hospital. The papers appearing now focus attention upon the hospital as an institution devoted to the welfare of the people and as a potent force in the life of a vigorous university. We are grateful to Dr. A. L. Swanson, executive director of the hospital and a former editor of this journal, for arranging to make these papers available to us and we present them in the firm belief that our readers will find here much that is informative, forward-looking, and inspirational. (See pages 33-44.)

Malcolm T. MacEachern

LE MONDE a perdu un chef remarquable, et le Canada, un fils célèbre. Son nom était reconnu partout où s'assemblait le personnel d'hôpitaux. Physicien, professeur, écrivain, rédacteur, administrateur et conseiller — il a consacré sa vie et un talent exceptionnel pour améliorer le traitement des malades dans les hôpitaux de l'Amérique du Nord et dans beaucoup d'autres coins du monde. Ses qualités personnelles et ses efforts de pionnier dans sa zone d'influence lui ont donné la réputation d'un croisé moderne. On n'oubliera jamais son nom en parlant du programme de normalisation des hôpitaux du Collège américain de Chirurgiens—qui a précédé la Commission Collective pour l'Accréditation des Hôpitaux. Le "Docteur Mac" a beaucoup voyagé aux Etats-Unis et au Canada et souvent en d'autres continents où l'on a demandé son conseil qu'on estimait d'une grande valeur. Il a reçu, pendant sa longue et illustre carrière, des honneurs innombrables en reconnaissance de ses contributions au bien-être universel, aux arts et aux sciences. Il s'intéressait toujours aux hommes comme individus, et par sa manière amicale et sa gouverne aux conférences il a mérité l'amitié de milliers de gens.

Le président et le Bureau de Direction de l'Association des Hôpitaux du Canada, au nom des associations membres et des conférences catholiques, offrent, à Madame MacEachern et à sa fille Isobel MacEachern Mackie, leur profonde sympathie.

CHAM Under Revision

IN OUR issue of October, 1951, there appeared an announcement entitled "Operation CHAM". In the months that followed, the *Canadian Hospital Accounting Manual* was compiled and published. When the manual was little more than a year old, Dr. O. C. Trainor, in his presidential address to the twelfth biennial meeting of the Canadian Hospital Council, stated, in part: "I think it no exaggeration to say that no effort of the Council since its inception is likely to have such a profound and lasting effect for good as this same CHAM."

In the intervening years this sentiment has been reiterated many times. From all that we have seen and heard, we can only conclude that the accounting manual has been of immense service to the hospital field in Canada.

Like any other similar work, the accounting manual is not "time-proof". Changing circumstances and conditions in the hospital field require appropriate amendments in accounting and in the system of recording hospital statistics. The revision is taking place at a time when the forces of social progress in Canada are pressing steadily forward and at a time when possible radical changes in the whole system of financing hospital care seem imminent. The revision of CHAM is a matter in which every accountant, administrator, and trustee has an interest, and attention is directed to the article appearing on page 66 and, particularly, to the appeal contained at the end of the article for ideas and suggestions relating to the content of the second edition of CHAM.

Joint Commission on Accreditation Drops Point-rating System

JUST AS ALL sound organizations progress with the times, so has the Joint Commission on Accreditation of Hospitals. Recently the Commission has taken a good look at its work tools, with the result that a revised report form is now being used by the surveyors. A number of changes have been made which are of interest to *all* hospitals. One change is that the point-rating system is no longer used. Instead of an evaluation largely based upon the number of points received, the judgment of the surveyor and the subsequent review by the Joint Commission will now determine if the hospital shall obtain provisional or full approval.

Pharmacy and drug control, formerly a complementary division, has now been made essential; that is, along with the usual eight departments in this category, a hospital must maintain a pharmacy or controlled drug storeroom, with a satisfactory system for control of the drugs, before it can be considered for accreditation. This does not mean that a qualified pharmacist must be employed.

Three new divisions have been added to the complementary and service group. These are: (1) dentistry, where the emphasis is on the integration of the department with the medical staff organization and services; (2) emergency, in which considerable importance is placed upon how well the facilities meet the needs of the particular area; and (3) special services, to provide for some categories which were formerly included elsewhere. It is this last division which indicates that the members of the Joint Commission have exhibited considerable interest in aiding the small hospital to become accredited. Such services as an intern staff and a school of nursing were formerly allocated marks in the essential divisions of medical staff organization and nursing service, respectively. In many small hospitals they were simply not feasible and the altered report recognizes this by including them as part of special services in the complementary division. A cancer control program and routine chest x-rays are also included in the special services category. In the same manner, pathology and x-ray departments concentrate more upon the adequacy of the facilities and staff for the particular hospital than upon work which could only be done satisfactorily in a large department with expensive equipment and staff with specialized training.

There are many small changes throughout the surveyor's report form; most of the questions which must be answered factually and do not require the personal judgment of the surveyor have been included in a greatly enlarged questionnaire which is sent to a hospital prior to the visit of the surveyor. Consequently, there is more emphasis placed upon the surveyor's evaluation of the adequacy of a department and less upon specific points. Some of the divisions, however, such as that dealing with the physical plant, have become more detailed with added questions about fire prevention, reports of the Fire Marshal, and emergency lighting. All the answers to the questionnaire and the survey report are important. The emphasis appears to be ever more consciously placed upon quality of the services, with adequate care and safety of the patient clearly to the fore as the constant objective.

Accreditation of Interest to All Hospitals

TODAY ACCREDITATION as a topic appears frequently on the agenda of conventions and institutes, as well as in the pages of hospital journals. However, representatives of hospitals with fewer than 25 beds sometimes express the opinion that accreditation is of no interest or concern to them, since only institutions having over 25 beds are surveyed. Even when hospitals qualify as to size, officials of smaller ones often consider that their type of medical staff organization would not permit them to become accredited.

Most small hospitals find it difficult to organize their medical staffs and this is very evident where there are only two or three doctors on the staff. At the 1955 Western Canada Institute for Hospital Administrators and Trustees, much discussion ensued regarding this point. One specific question asked was how to organize when there is only one doctor. To the hospitals concerned this was no facetious question. The case was not an isolated one, as it represented the experience of many hospitals. Could one doctor be expected to carry all the various offices of medical staff organization and act on several committees as required? Whether or not those hospitals considered they received a satisfactory answer to their question, it will be good news for them to learn that a 26-bed hospital in Alaska, which has one staff doctor, has been fully approved by the Joint Commission on Accreditation of Hospitals. This news should act as an incentive for hospitals in the 25- to 50-bed groups, with small medical staffs to strive for accreditation.

The standardization program conducted for many years by the American College of Surgeons and now by its successor, the accreditation program of the Joint Commission, continues to assist in improving hospital and medical care in North America. The program of hospital accreditation represents many things but, above all, it is a program of education. While it is true that hospitals with less than 25 beds are not surveyed, this does not mean that such hospitals cannot benefit by the program. Trustees, medical staffs, and the administrators of small hospitals are all interested in improving the calibre of patient care. Those hospitals which make use of the literature available on accreditation, and apply it to their own situation, will find their hospital and patients are deriving much benefit.

Changing Emphasis in the

Functional Role of the Hospital

Harvey Agnew, M.D., LL.D., F.A.C.P., F.A.C.H.A.,
Prof. of Hospital Administration, University of Toronto, Toronto, Ont.

IN LETTING "the great world spin forever down the ringing grooves of change", we find the hospitals participating in those changes. The hospital of today has evolved a long way from the ancient pagan temples with their far-from-scientific rituals and from their unhygienic successors of the Dark Ages, or of the Renaissance period. The present-day hospital—particularly if provided with the facilities available in your University Hospital —has become a great medical workshop where modern miracles are performed every day, where people recover who really could not expect to recover, when specialized training is proceeding apace and where new ideas are constantly being developed and applied.

Nor do we believe that we are more than part way along the path of hospital evolution. Undoubtedly new principles of treatment and new technical procedures will develop over the years. These cannot be foreseen. But we can see more clearly extensive changes in the *functional role of the hospital* and that is the theme of these brief remarks.

These changes may be linked with sociological developments, particularly with respect to the financing of hospitals and of hospital care. As society becomes better organized, much of the financial burden of illness will be shifted, not necessarily from the individual, but at least to the period when he can assume it without sacrifice.

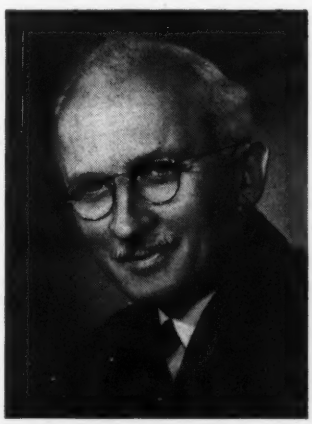
With doctors' offices and research and educational activities being centred to a greater extent in the hospital, and with the likelihood of home care for many cases becoming part of the hospital's responsibility, the hospital is gradually but definitely becoming the focal point for many aspects of the over-all health program which, until recent years, seemed to have little connection with it.

More Co-ordinated Health Programs

One sees much of the haphazard and the "topsy" type of expansion being taken out of our health programs. It means too much to our national welfare for us to continue indefinitely with unco-ordinated and often completely unrelated group and individual efforts. There are still too many gaps in our services, too many difficulties in getting maximum efficiency out of what we have, too many handicaps in providing trained personnel.

At the same time, one cannot say enough in support of the magnificent work being done by so many of our voluntary groups and public-spirited individuals. We sincerely hope that their work will go on indefinitely; for I am one of those who believe that it will be a sad day indeed if the spirit of personal voluntary service is ever permitted to die out.

The health program developed in Saskatchewan in recent years has been of inestimable value in indicating what can be accomplished by co-ordinated effort in the health field and without interfering with autonomy and the incentives of voluntary effort. This is indeed a valuable contribution in our evolution towards a fully satisfactory health organization.



Harvey Agnew, M.D.

In the health program of the future we see better teamwork between government and the voluntary bodies, with the medical profession, the nurses, hospitals, public health, welfare and all related agencies participating as a team in effecting better diagnosis, treatment, follow-up, medical and related education and rerearch. In this program we see the hospital taking an ever more important part.

Personnel Problems

Some of these developments will probably come gradually over the years. But the recruiting and training of the great army of skilled personnel required is a very present and harrowing problem of today. The great expansion of hospital facilities in the past decade has pointed up as never before the necessity of working out lasting solutions, not merely on a local, but on a national basis.

Government assistance in educational programs has been most helpful, but the problem is far from solved with serious shortages in practically every field of hospital work. For certain vocational groups, as, for instance, medical record librarians, and technicians in medical fields such as radiology and pathology, there would seem to be a definite shortage of recognized training facilities. For others, such as nurses, there are usually adequate schools but not enough qualified instructors.

Shortages in most skilled groups on hospital staffs are becoming so serious that, with the steady increase in beds and facilities required, obviously we must evolve new methods of providing care in our hospitals. Somehow we must get more results with fewer people. We must conserve the time and narrow the duties of those with special skills, although this is an almost insurmountable problem in small hospitals. More mechanization will be needed but we must be sure that the expenditure results in a real reduc-

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From an address delivered at a special convocation of the University of Saskatchewan, May 14, 1955, *at which several representatives of the health field received honorary degrees (see "The Canadian Hospital", May,* 1955, *p.* 12). *The convocation was part of the ceremonies held to commemorate the opening of the new University Hospital, Saskatoon, and the expansion of the university's Medical College to include a complete medical course.*

tion in staff required, not merely more idle time for the same number.

We must curb the tendency today to send (or go) to hospital for conditions not really needing hospital care. Fewer diagnostic admissions for those who can receive these services without admission and earlier discharge of the chronically ill to home care facilities, or to other institutions, would help.

We may be forced to omit or (on the surface at least) reduce desirable features of some services. No one likes to reduce standards, or to accept substitute personnel, especially if these changes appear to lead to permanence. But we might as well face facts and realize that the major alternatives in the near future will be either inability to operate much-needed new hospitals, or to develop new procedures making fewer demands on the more highly trained echelons. With the increased use of nursing and dietary assistants and the present emphasis upon mechanized services, we have begun to grapple with the situation.

I am hardly prepared to predict that patients will be put upon conveyor belts, given a handful of slugs and get a nightshirt, some sandwiches and coffee, sleeping pills and fresh dressings as they move along past slot machines — not to mention a possible x-ray, a bath and perhaps an operation or two! But we are likely to see more movement of patients from well-staffed areas for the acutely ill to less well-staffed wards or wings for the sub-acute and convalescent stages.

Education of Personnel

The problem of providing educational facilities for the various professional and technical groups required in this technocratic age is one that has given much concern to many of us. Undoubtedly the establishment of courses in junior colleges and technical institutions would provide for at least a portion of this training. But some of us feel that, for certain groups, the mere acquisition of technical knowledge of vocational value is not the sum total of what they need for their work.

They should have the privilege in the more extensive under-graduate courses, and at the graduate level, of absorbing something of the atmosphere of the campus and of the many contacts which so enrich the lives of those who have had the privilege of university experience. We cannot share the opinions of some that most of those who take courses, graduate or under-graduate, which are primarily of vocational value, especially if in the technical, scientific or business fields, should be relegated to outside institutions and denied the privileges of university association.

A. N. Whitehead in his *Science and the Modern World* did not criticize specialization in education; but did believe that it should be accompanied by influences which lead to what he called greater "appreciation of variety of value". He believed that we are "far too much occupied with intellectual analysis". In sharing this viewpoint, Sir Richard Livingstone in his *Education and the Spirit of the Age* states that "the remedy is, not to dole out snippets of history, literature, art and science, but to develop a mind sensitive to values and aware of their infinite variety. . . . The important thing is to develop in the specialist a seeing, aware, wide-ranging habit of mind". One believes that this can be best achieved by university life and that its encouragement is a responsibility of universities.

> "If we accept the principle of the Ninth Roman Law that the health of the people should be the first consideration, medical education—and the best possible education at that—must be an essential feature of our society. That is not easy to attain, for it means more than the necessary buildings; it involves the difficult task of developing a highly qualified staff; of providing special teaching equipment; of providing clinical facilities and organization which will permit a level of patient care that can be an inspiration to the embryo leeches; and of maintaining vigorous growth and stimulus by extensive research and post-graduate teaching." – *G.H.A.*

On this occasion I am speaking primarily of the hospital and its potentialities. A university hospital, linked closely with such a progressive university, has a great opportunity to work out programs in education enriched by contributions from the various faculties which could well make this one of the great centres of health education in this country. Training in leadership should be a primary emphasis.

Undoubtedly a major reason for the creation of this great hospital was to provide the clinical opportunities for the teaching of medical students and graduates. However, one sees here also the possibilities for both full-length and short courses for technicians in several fields — for medical record librarians, for physical and occupational therapists, for nursing assistants, for dietetic assistants, for social workers, for administrative residents and for various other groups for whom training facilities are now either inadequate or even lacking in this province.

The Practising Physician

From the viewpoint of its far-reaching effect on human welfare, one of the most important functions of the hospital is the education of its medical staff. But this hospital should do more; it has the opportunity — and the responsibility — of giving all doctors in the province the benefit of its educational influence. Many practitioners today have great difficulty in getting away for the so-essential post-graduate refresher courses. Even when the spirit to go survives the deadly effect of daily exhaustion, it may not be possible to leave the seriously sick for any length of time. A hospital in a centre like this, by beaming short courses to the rural doctors, can do an inestimable service in maintaining and still further raising the level of medical knowledge and skill in this province.

A Needed Factor in Education

One indirect effect of the educational opportunities centred in our hospitals is the development thereby of a trait which we find so sadly lacking in altogether too many people today. I refer to the attribute of personal responsibility. Whether the stunting of this trait is characteristic of a paternalistic era, or to group protection of mediocrity, or whether it is engendered by theories of education which subordinate discipline and conscientious acceptance of duty and responsibility, is a matter of opinion. We do know, however, that in our hospitals, where human life is constantly at stake, it is stressed, and stressed repeatedly, to the nurse in training, to the medical student and to the technician, that mistakes simply must not be made and that the welfare of the patient must always come first. Were this not so, health care today would be a long way below its present high level of attainment.

The greatest contribution may come in research. With your highly competent and enthusiastic medical staff and excellent clinical and laboratory facilities, your future as a research centre should be an enviable one. ●

—*a symposium*—

The Hospital in Tomorrow's World

Introduction

(These remarks are taken from Dr. Macleod's introduction to a symposium on "The Hospital in Tomorrow's World", which was presented at the opening ceremonies for the new University Hospital, Saskatoon, Sask., May, 1955.)

J. Wendell Macleod, M.D.,
Dean of Medicine,
University of Saskatchewan,
Saskatoon, Sask.

THE PURPOSE of this symposium is to indicate the course that has been charted for the new University Hospital, Saskatoon, Sask., and to receive advice from a group of seasoned and venturous navigators. Their accomplishments in the world of health and their clear view of the shape of things to be should make their utterances both provocative and prophetic. An alternative title for this symposium was "Health Care in the Second Half Century", thus stressing the breadth of our concern and its scope in time. Here today are medical students who will be the first to complete their studies in Saskatchewan. They will receive their medical degrees in 1957; if they intern for two years, then practise for another forty, it will be the year 2,000 A.D. The date is challenging in itself. What will our world be like? The question is not rhetorical because a hospital is not an island in time or in society. It is an integral part of the health world and this we know reflects and influences all aspects of human life.

Certain features of the future may be surmised by projecting the trends of the past century. We have seen the impact of unprecedented scientific advance and this we may expect to continue. There has been a better understanding of the social forces and historical events which modify our health concepts and practices. Medicine has extended its concern from the purely curative to include the preventive; from measures applicable only to the individual to those receiving public administrative action, techniques which no doubt will be perfected. Finally, we have seen the growth of widespread and insistent interest in exploring the nature of personality and the dynamics of human behaviour. Just as we are earnest in trying to understand ourselves as individuals — and collectively as communities — so too there has been the desire to understand our institutions.

A hospital is an institution and as such is subject to the diseases and complications of institutions. Understanding of hospitals, as social institutions, is increasing so rapidly that soon some one will write a comprehensive thesis on the natural history of hospitals and the epidemiology of their diseases.

Two years ago, Dr. Allan Gregg, taking part in the opening of a new wing to the Montreal Neurological Institute, spoke on medical institutes as social institutions. Almost every point he made would apply to teaching hospitals. "All human institutions", he said, "must reckon with two forces. One is the inherent intent to supply stability of purpose and effort; the other is to be promptly and delicately responsive to changes in the environment and even changes in objectives. Stability can be pushed too far; it must reckon on adjustability if we are to survive. All institutions", he went on to say, "maintain a precarious balance between opposing forces, tenacity in the face of adaptability, stability risking extinction in a world forever changing."

The purpose of this symposium, then, is to help a new teaching hospital so to define its philosophy and goals that the stabilizing influences will be nicely balanced by those that keep us in touch with a changing world; to avoid, on the one hand, a too sensitive heeding of irresponsible clamour and insignificant events and, on the other, to avoid spiritual calcification that would make us too rigid to bend in the face of the force of human need.

J. Wendell Macleod, M.D.

Background of the

University Medical Centre

W. S. Lindsay, M.D.,
Dean Emeritus of Medicine,
University of Saskatchewan,
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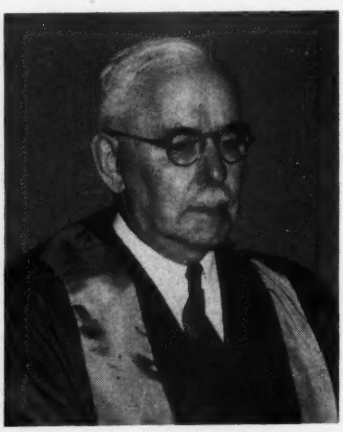
MY PART IN this symposium has little to do with tomorrow's world. Rather it has to do with yesterday. It is a story which had its beginnings in the anxiety of the people of these western plains for two things, education and medical care. If anyone is surprised that this relatively poor and sparsely settled province should saddle itself with a new medical school, let him realize that this is perhaps the one enterprise in which these two fundamental cravings could be combined.

Even before this province came into being its people had begun to think and plan for a university and one of the first accomplishments of the newly formed legislature was to pass the University Act setting up a University Board and giving it authority to establish a provincial university.

The first major problem facing the new board was the selection of a president, solved happily by the appointment of Dr. Walter C. Murray, a New Brunswicker, then holding the chair of philosophy in Dalhousie. It was Dr. Murray who set the pattern for the new university. It was not in his mind to set up an isolated bastion of culture, an ivory tower where a learned staff could toy happily with abstruse ideas, undisturbed by the realities of drought and frost, hail and rust. It was a down-to-earth university that he wanted, with its roots sunk deep into the Saskatchewan soil. This does not mean that he, and it, were unconcerned with learning for its own sake. This is clearly shown by his early staff, men like Oliver, Brehaut, Sullivan, Moxon, Morton, and Bateman, in the humanities, and Ling, Thompson and Thorvaldson in the sciences. But ever in his mind was the conviction that this university owed its existence and belonged to the people of Saskatchewan; and that its primary concern should be the welfare of those people who, in the midst of a grim struggle for the bare necessities of life, could dream dreams and give generously from their hard-won earnings to provide opportunities for their children that they themselves had missed. And so the University of Saskatchewan became and has remained, more perhaps than any other Canadian school, the servant of the people.

There is not time, nor is this the occasion, to trace the history of this university. It grew and won for itself an honoured place among Canadian schools. As the needs of the province demanded, various faculties and colleges were added — Arts, Agriculture, Engineering, Law, Pharmacy and others. Medicine seemed out of reach; the province was too small, the people too scattered, the economy, dependent almost wholly on wheat, too restricted. But it needed doctors and its people wanted their sons to have the opportunity to become doctors.

And so a compromise was reached. If, because of an assumed lack of clinical material, and a real lack of money, it was felt that we could not aspire to a full medical school, might we not manage the basic medical sciences and so lessen by two years the time our students had to spend abroad. So it was that in 1926 the School of Medical Sciences was started — in a greenhouse. Dr. Murray had no love for temporary buildings and there was not money to build permanently in the style to which we were by then accustomed. He could spread himself to a couple of greenhouses and, in an agricultural province, greenhouses could always be turned to some useful purpose. So we got two and never were greenhouses turned to stranger ends; one became a dissecting room, the other a physiological laboratory and, strange to say, from these meagre and spartan quarters Dr. McGibbon and Dr. Scott turned out young men and women who seemed to hold their own reasonably well with the more favoured students of the larger, better equipped schools in the east.



W. S. Lindsay, M.D.

And there matters seemed to stand, and might have stood indefinitely, had not the world come down with a second world war and the federal government announced in 1942 its plan to inaugurate a scheme of national health insurance. More doctors would be needed but where would they be obtained? The older schools were insistent that their classes could not be appreciably enlarged without sacrifice of standards. New schools were desperately required and British Columbia and Saskatchewan were asked to establish Faculties of Medicine.

We needed doctors. Statistics showed that in provinces with no medical school comparatively few students entered medicine. More than that — of those who left the province to study medicine, three quarters failed to return. Even more serious was the fact that that three quarters included an undue proportion of the better students. This was only to be expected —the best students received the most tempting offers. But over the years the continued skimming off of the cream of each class could not fail to affect adversely the standard of medical practice. So quantitatively and qualitatively the province was suffering from the lack of a medical school.

It was realized that medical education is expensive — how expensive we did not then appreciate. The figures compiled from our limited knowledge and experience were sufficiently staggering, though they now appear ludicrously low. Had the full extent of the undertaking been realized at its conception, the embryo medical school might well have died aborning — a melancholy thought. We remain convinced that the development of a teaching centre here—the school, the hospital, and whatever ancillary institutions may be added later*—will do more for medical practice throughout the whole province than could be obtained in any other way.

What then of the obstacles, the cost, the feared shortage of clinical material, the difficulty of obtaining teachers? Of

*Already there is promise of an Institute for Medical Research and a nursing home for aged patients.

these, it was the last that gave us most concern. A medical school can be no better than its staff. Could a university like this, situated in a small town dependent for its existence almost wholly on agriculture, hope to attract the teachers needed to ensure a first class school. If not, we might as well give up. There is nothing more useless or dangerous than a second class medical school and we wanted none of that.

This is where Dr. Macleod came in. He faced a difficult task. Aided by generous grants from the Rockefeller Foundation and the Commonwealth Fund he spent a year visiting some of the most famous and progressive schools on this continent and in Europe. Many new and revolutionary ideas in medical teaching were under trial. Dr. Macleod tried to see and examine them all, and from what he saw he picked and chose, critically and carefully, whatever fitted our local needs. The result has been a new and forward looking curriculum. His plans have still to prove themselves on students but they have dissipated once and for all the fear that we might not be able to attract the right type of staff. It is of course unseemly to appear complacent before we have started a single student into his third year, but we might be permitted to admit that we like what we have seen of the men who have come to head our clinical services and expand the various departments. From the vantage point of retirement I can say this without immodesty, since the only credit that I can take to myself is that I did have something to do with persuading Dr. Macleod to come in the first place. It was to me a very happy

(Concluded on page 64)

The University Hospital and

Clinical Investigation

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CLINICAL INVESTIGATION is, of course, the accurate observation of a patient or a number of patients over a period of time, repeatedly and, sometimes, in a very detailed manner. One can observe the patient by the direct aid of the senses; or one can extend those senses by laboratory procedures, using more or less complicated pieces of apparatus. These methods are complex and to use and interpret them accurately requires prolonged training. While, just as it is possible to run a car without being a mechanical engineer, it is possible to use these tests without knowing the basic physics or chemistry upon which they depend, the usage will not be adequate. For one must understand something about their possibilities, limitations, and sources of error; and that requires either that one has a knowledge of the basic science on which these methods rest and of the physiological and biochemical processes which they reveal, or that there are in that institution individuals who have the knowledge and are willing to share it.

Knowledge alone, however, is not enough. Of vital importance to clinical investigation is that capacity to wonder, which tends so often to be destroyed in acquiring the knowledge which should encourage it. Robert Gibbins, in a book about the river which flows into the sea at Cork, called *Lovely Is the Lea*, describes one of his characters as follows: "He was a man who never ceased to wonder". Wonder, unfortunately, can be obscured much too easily by our concern with facts. There was once a Presbyterian minister in Gaspé where I was brought up, who wrote poetry. On one occasion a young geologist came and addressed a local meeting. The minister read me a poem describing this young man as a puppy scratching away at the roots of the tree of life and completely ignoring the huge tree growing and flowering above him — he was getting at the roots of the matter. This sometimes happens in clinical investigation. We are so concerned with getting at root one, branch three, sub-branch four, section five, tendril six, that we don't see the tree at all.

Of course, wonder which does not bear some kind of concrete result is incomplete. The following is a story of a great discovery and how it was made. The man who made it was Otto Loewi, who is now 82 years old and the greatest man I am personally acquainted with. On Easter Sunday morning in the year 1922, he woke up at 3:00 with the idea that the vagus works by means of liberating a chemical substance, *and* with the plan of an experimental method of proving it. He reached over to his bedside table, wrote this idea down, and went to sleep again — a remarkable example of control. He woke up in the morning to find that the paper he had written the note on was so thin that his pencil had gone through it and he could not make out what he had written. He knew it was a wonderful idea; unfortunately, he couldn't remember what it was. The next morning at the same hour he woke up with the same idea and knew again how he could prove it. This time he got up, dressed, and went to the laboratory. There he took a frog, opened its heart and put some salt solution into it; then he stimulated the vagus nerve attached to the heart which, of course, slowed down. Then he took the salt solution from that heart, put it into another frog's heart, and the second heart slowed its rate of beat without the vagus being stimulated — showing that his idea was correct. He then rushed to the assistants' room, calling out, "Come out, come out, I have found something wonderful". They only said, "Go away, Herr Hofrat (a sort of super professor). This is a holiday, we are not coming out for anybody until 9 o'clock". So he went away and danced up and down. They

J. S. L. Browne, M.D., C.M.

came out at 9 o'clock and repeated the experiment. He later received the Nobel Prize.

Now that seems all very simple. Professor Loewi was telling this story in 1929 in Boston at the International Physiological Congress and Sir Michael Morley Fletcher, then secretary of the British Medical Research Council, said, "Loewi, that is quite wrong. I have it in my diary that when I was working with you in Marburg in 1907, we were walking outside the village about sunset and I said to you, 'Doesn't the village look nice in the sunset?' and you said to me, 'Don't bother me about the sunset. I am thinking that the vagus may work by means of a substance.'" He had had the idea in 1907, but without a method of putting it into experimental reality. It came back to him, for some reason which I do not know, and neither does he, in 1922, together with the method of proving it experimentally. He received the Nobel Prize for proving it in 1922, not for the idea in 1907.

Thus, in doing scientific investigation, clinical or otherwise, it is the carrying out of it which matters. It is not the wonderful ideas or the armchair reasoning — though these are necessary. The development of accurate methods and the carrying out of experiments takes time, space, and personnel. It must be realized that if these are overstrained by the demands from people who have no concept of the time it takes to carry these into experimental reality, then the personnel, the apparatus, and the space become swamped and cannot function efficiently.

The stimulus to clinical investigation can come through the basic sciences and be applied to man. Many of the new ways and procedures of working come by this path. Conversely, the stimulus can come through observing a patient — you will notice I do not say disease. We have, from the point of view of clinical investigation, a bad habit of pigeon-holing a patient after labelling him with the name of a disease. We think about the patient when he first comes into hospital, when we first see him; perhaps we think about him quite a lot, do various things about him. Then we put a name on him, tie him up with pink or blue ribbon and drop him into a pigeonhole — and forget about him. I am not suggesting, of course, that the patient is neglected in terms of his treatment or clinical follow-up, but merely that we tend to cease thinking about him in terms of his physiopathological state as soon as we have named his disease. Thus we do not observe him as accurately as we did prior to the diagnosis or pigeon-holing, and we tend to attribute variations in his state to the clinical entity, rather than think carefully about the factors which brought them about. Now, you cannot do that if you are doing clinical investigation. You have to re-open your mind to the necessity for accurate observation of the patient all the time you are considering him or her. It is just as important that the facts about the patient, as observed by your senses, be accurate and be recorded, as it is that a complicated instrument be properly used, or that radioactive isotope or steroid excretion in the urine be accurately measured.

The University Hospital, geographically situated near the University, is ideally located for the carrying out of clinical investigation because of its juxtaposition to the basic sciences, the social sciences and the humanities. Geographical juxtaposition is, however, not sufficient. There must also be psychological juxtaposition, with the free conversational inter-play between these various groups which is, after all, the essence of a university. University Hospital itself has side by side, a number of different disciplines, called departments, all of which may be more or less separate. But the various techniques are available when they are needed; while there is also the conversational juxtaposition of the lunch room. Here, it is true, things other than medicine may be discussed but a good many inter-departmental problems can also be solved by conversational interplay. I recommend this form of interplay in addition to more formal conferences.

A university hospital is, then, an

(Continued on page 98)

The Scientific Medical

(With apologies to the shade of W. S. Gilbert)

I am the very model of the Scientific Medical.
I know each nerve and artery, each ligament and pedicle;
My knowledge has been built by evolutionary processes
From Galen and Hippocrates to present day collossuses.
I've studied all the endocrines and know the various offices
Of pancreas and thyroid, or of thymus and hypophysis;
I know the suprarenals too, and all that they're related to,
(- - lated to, - - - lated to, ah)
I know the pH value of ionical acidity,
I calculate percentages with wonderful rapidity,
And when it comes to artery or ligament or pedicle
I am the very model of a scientific medical.
I'm particularly expert at a Wassermann analysis,
I hunt for protozon in a patient with paralysis;
The chemistry of insulin's a subject that I revel in
And antitoxin therapy I'm just the very devil in.
I know the role of calcium in various forms of tetany
I understand trypanosomes, although I've never met any;
And I've the latest news on perineural sympathectomy,
(- - pathectomy, - ectomy, ah, I have it)
My knowledge often bringing in a good substantial cheque to me.
I'm very strong on vitamins and matters dietetical;
I know the graphic formulae of remedies synthetical;
And when it comes to artery or ligament or pedicle
I'm just the very pattern of a scientific medical.
(More slowly and sadly)
When I've acquired some knowledge about matters pharmaceutical;
When I can diagnose a little deeper than the cuticle;
When simple indigestion has become a trifle clear to me;
When babies with the colic are no more a source of fear to me;
When I can write a recipe with ordinary galenicals;
When I have learned the doses of the various arsenicals;
When highbrow scientific lore no longer needs a missioner;
(missioner, - - condi, practi - - I've got it)
You'll then consult me safely as a general practitioner.
For my scientific knowledge, though I'm always up to date with it
Has kept me back with practice, and I'm just a little late with it
But when it comes to artery or ligament or pedicle
You'll find I'm just the model of a scientific medical. —

From the "Journal of Chemical Education", March, 1929. *Anonymous.*

Improvement of Patient Care and

The Social Sciences

Esther Lucile Brown, Ph.D.,
Executive Staff,
Russell Sage Foundation,
New York, N.Y.

THE TWENTIETH century, particularly the decade since the end of World War II, has seen a vast expansion of hospitals, out-patient clinics, health agencies, and bodies charged with planning for the health services in large parts of the Western world. The magnificent new University Hospital in Saskatoon takes its place among the proud guardians of what modern medical science and hospital construction and administration have been able to achieve. I speak, however, not of hospital buildings as such, of the achievements of the biological and physical sciences, or of the practice of medicine in which I have no competence, but of patient care as it is provided within the hospital and as it is experienced by the patient.

For some fifteen years now there has been increasing concern, both by the staffs who provide that care and by the patients who experience it, lest we be failing even to maintain standards comparable to those that existed prior to the past war. In techniques for diagnosing, treating, and preventing disease, we have shown pre-eminent success. But what about relationships with patients and the contribution of those relationships to the healing process? Let us take a brief look at patient care as it would probably appear to social scientists, as well as to many members of the health services, who visited a succession of large general hospitals that had well-established reputations in diagnosis and treatment of disease and laboratory research.

Lack of Team Work

Observation of floors or wards would reveal much movement, often hurried and sometimes confused, by staff of many different categories including several new groups of assistant personnel. Almost everyone would be carrying out a procedure ordered by the appropriate person in the service with which he was associated. Even if he were a member of the regular ward staff and not from another department, however, he would rarely seem to be part of a *team* whose efforts had been closely co-ordinated on behalf of helping patients to manage the problems of illness, particularly psychological problems. Very infrequently would one see the members of the ward staff sitting down together at a conference table for regular and systematic discussion of the needs of individual patients and how those needs could best be met.

Patients report that they find the stream of personnel who do something *to* them or *for* them but rarely *with* them extremely disconcerting and fatiguing. Instead of gaining psychological support they have a sense of vast aloneness and often increase of anxiety. When ward staff is asked whether group planning could not lead to reduction in the number of personnel serving a particular patient, and whether it is not possible for someone — physician or nurse — to sit down quietly with, and listen to, the patient for a few minutes each day, the questioner is promptly told that present deficits in ward care are the result of serious numerical shortages, particularly of nurses. That grave shortages exist in many geographical areas that have been rapidly expanding their medical and health services, as well as in practically all psychiatric hospitals, is factually correct; but to make these shortages bear so large a responsibility for inadequacies is to preclude examination of other essential factors.

Social Environment

The average general hospital is still organized to take care almost exclusively of patients who are in bed, although early ambulation has greatly reduced the nature of hospitalization. The social scientist is surprised at the absence of convenient lounges furnished with books, magazines, and games, and the absence of facilities for showing films, serving tea, or providing other social activities. From the lessons learned by psychiatric hospitals, and paediatric and rehabilitation services, are we not to conclude that all ill patients need a social environment more nearly resembling that of the home and community which would give them some sense of contact with the outside world, some distraction from preoccupation with illness, and would perhaps reduce the demands for service made upon the ward staff? If there be a shortage of personnel, could a social setting not be created that would minimize this inadequacy somewhat and would allow patients themselves to give more psychological help to other patients?

Esther Lucile Brown

Rehabilitation

Although large numbers of persons are employed in doing something *to* or *for* the patient, examination of ward care reveals that systematic plans for teaching patients how to care for themselves after leaving the hospital, or facilities for the maximum rehabilitation possible while in the hospital, are rare indeed. Many individual patients certainly receive excellent instruction from physician or nurse and an increasing number of hospitals are concerned with problems of rehabilitation. But for numberless other patients responsibility appears to end when the acute phase of the illness is over. Everyone is so well acquainted with the serious consequences for the patient, which may bring about discomfort, anxiety, and often needless readmission to the hospital, that no illustrations are necessary. The question is: "Why is it impossible to provide at least the essential guidance, even if rehabilitation cannot be supplied?" The answer probably lies chiefly in the fact that there is no clear allocation of responsibility among personnel as to who is to do the teaching, or insufficient supervision, if responsibility has been assigned, to guarantee that the teaching will be consistently performed. And the reason for failure to determine who shall assume the responsibility is rooted in considerable part in the inadequacy of communication that exists among the categories of staff concerned with patient care. ➡

This paper is being published simultaneously in "The Canadian Nurse".

Communications

This last conclusion brings us immediately to one of the most serious problems in its consequences for patient care; but one of which physicians particularly seem so little aware that something must be said about it in greater detail. It is the distressing lack of communication between the two professions most directly and intimately in contact with the patient, namely the doctor and the nurse. So incredible does this phenomenon appear to the social scientist, when he first begins objective observation of hospitals, that one sociologist periodically stationed himself near the charge desk on various wards to count the number of exchanges — of no matter what nature — between these two groups of staff. His count showed that physicians spoke to physicians, even at the head nurse's station, *eight times* as frequently as they spoke to nurses. If this occurs in a fine voluntary hospital that prides itself on administrative competence, is it any wonder that a lay board member of another hospital characterized this social distance between the two groups as a "barren no-man's land"?

What are the consequences of such failure in communication for the patient? One brief illustration will have to suffice. In a particular hospital which I was visiting, it was suggested that I talk to the head nurse of a ward for veterans with long-term illness, because she was so exceptionally competent and highly motivated in the care of chronic patients. In describing the various patients and the nursing problems presented, she came to the name of Mr. M. "Last night he told the nurse," said she, "that he did not expect to live. We had no idea that he had anxiety about dying, particularly when his condition is so much better than that of the other patients." "And what has been done to relieve Mr. M. of anxiety?", I inquired. "The night nurse reported it to me and I have reported it to the resident," was the reply. "Do you know whether the resident has already had a talk with Mr. M.?", I queried. She did not know. "Do you think he *will* talk with Mr. M. — and very soon?" She refused to hazard an opinion. When I inquired what she considered was her responsibility, knowing as she did that a patient was afraid he was going to die, she only said again that she had reported the matter promptly. "But couldn't you ask the resident, with a smile, 'Did you remember to see Mr. M.?'" To this she answered, "You have been discussing with us in the hospital the value of ward staff meetings at which we could talk about the management of patients. If we are able to start such meetings, problems like that of Mr. M. can be taken up."

The only difficulty with the proposed solution was that such meetings would not be instituted for weeks at best, and Mr. M. was suffering anxiety. Here was a thoroughly experienced nurse whose interpersonal relations with patients, as I watched her, appeared so excellent that she could probably have allayed Mr. M's fears in short order. Yet she did not feel free to assume that responsibility or even to make certain that the resident physician had assumed it. We can only infer that the institutional system of the hospital, a subject to which we shall return soon, had produced this strange pattern of behaviour.

Motivation

Detailed observation of patient care and interviews with personnel lead to the conclusion that motivation is often inadequate and morale low among many members of ward staffs. So poor indeed does motivation frequently appear that we must ask whether the roots of the present problems do not lie here quite as much as in numerical shortages. In hospital after hospital that is favoured with relatively large staffs and excellent equipment and facilities of the traditional kind, administrators admit that if only the resources in personnel and equipment could be fully mobilized patient care would probably be greatly improved.

When members of the staff are interviewed by a social scientist in whom they have confidence, recurring opinions and emotions are expressed that perhaps explain the half-hearted interest. If these opinions are sorted and arranged according to their frequency, the interviewer is likely to discover that, above everything else, staffs want to be found fault with less when the fault lies really in the hospital system rather than in their own neglect or shortcomings. Generally in second place is the desire by staff for recognition in the form of a word of praise or a smile when something has been done well. Relatively high on the list is the expression of need for stronger support from ward physicians or supervisory nurses in frustrating and anxiety-provoking situations. Parallel with the expression of need for support, however, is the desire to be consulted about patients' behaviour or what could be done to improve ward conditions. Interestingly, higher pay and shorter working hours, that management often concludes are workers' chief interest, are likely to be well down the list — and that in spite of the low salary scale of hospitals generally.

What hospital employees who work most closely with patients want, therefore, is much like what most workers elsewhere want: the sense that what they are doing is important, and that it is recognized, as such, both by those higher in authority and by their own category of staff. They want that recognition to be demonstrated in positive terms not only of praise and of being asked for opinions concerning ward matters, with which they are well acquainted, but they want to be given the feeling that they are *part* of a group therapeutic effort. In the failure of the hospital to supply these basic needs of its employees may lie an essential reason for patient care being impersonal, hurried, and neglectful of other than technical procedures. Is it not possible that floor staffs have lived in a cold, sterile atmosphere that has chilled them to the bone until they, in turn, reflect that atmosphere in their stiff and starched relations with patients?

This question brings us to the last point in this array of observations. The social scientist notes research laboratories where productive efforts are being made to further diagnostic and therapeutic goals. But he rarely finds comparable research concerned with assessment of the quality of patient care, with development of techniques for increasing effectiveness of relations between staff members and between staff and patients, and with evaluation of the results achieved. In a manuscript recently submitted to Russell Sage Foundation for publication, one of the authors has written the following paragraph about a hospital that for a decade has pioneered in studies of improvement of patient care. "As late as 1943 there was little research that tended to increase self-awareness; understanding of the manner in which each individual in the hospital setting was functioning, how he was contributing to therapeutic goals, and how his contribution might be implemented further. Although a few things within the hospital system were well studied, the system itself escaped notice, and (social science) research was not an integral part of the system."

Research of the kind referred to above has as yet been slight. What has been learned, however, from the application of concepts of behaviour to the field of industrial management alone furnishes sufficient guide lines for initiating hospital research and experimentation. Dr. J. A. C. Brown, a British psychiatrist, has simply and clearly synthesized this knowledge in

(Concluded on page 68)

Medical and Hospital Care—

Strengthening the Quality

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THE PRESENT, however glorious, is the child of the past. Saskatchewan's health program had its origin, before the birth of the province, in the infectious disease ordinances of the North-West Territories. With the establishment of a provincial government, a provincial medical health officer was appointed, and many in this audience will remember the pioneering efforts of Dr. M. M. Seymour, who served from 1906 to 1927. Under his effective leadership, the basic structure of a public health program was organized. Public health nursing services were launched; beginnings were made in the maternal and child health field; sanitary engineering was provided; and the Provincial Laboratory, started in 1905 as an agricultural function, became a basic part of the health department.

Virtually within a single generation, a series of outstanding health achievements earned for Saskatchewan a special place among the provinces of Canada. With the name of Dr. R. G. Ferguson is associated an anti-tuberculosis program that has toppled this disease from a leading to a relatively minor cause of death among Saskatchewan people. With Dr. F. D. Munroe, we associate the enlightened advancement of mental health facilities. With Dr. Alan Blair, we associate the Cancer Commission's clinics for diagnosis and radiotherapy that have now won world-wide recognition.

In these early years, also, there grew up in Saskatchewan patterns of organizing medical care and hospitals that were a remarkable adjustment to the needs of these thinly settled prairies. The municipal doctor prepayment plans, starting in 1915, helped to bring general practitioners to the crossroads and villages — the first governmental health insurance schemes on this continent covering whole communities and laying a foundation for much that has followed. The union hospital conception was hammered out, permitting rural and urban municipalities to unite for the construction and operation of general hospitals — a system that has helped to provide Saskatchewan with a supply of beds well in excess of other provinces and states of greater wealth. And in 1926, under the University of Saskatchewan, the School of Medical Sciences was set up to provide training in the pre-clinical sciences — the foundation stone of today's full-blown College of Medicine and University Hospital.

Health Decade

The last ten years in this first half-century of Saskatchewan's growth may well be described by future historians as the "health decade". For the years 1945-55, building upon the foundations of the past, have seen developments which place Saskatchewan clearly in the forefront of medical-social progress throughout the world.

You all know of the Health Services Survey conducted in 1944 under the leadership of Professor Henry E. Sigerist. From its recommendations there followed a chain of inspiring events which are still in progress. In 1945, the public health program was enormously strengthened by starting the organization of health regions. These bring modern preventive services closer to the people and place them under the guidance of citizens' boards, while still financing services largely from the more ample provincial revenues. The old municipal doctor plans were strengthened with a system of provincial grants which helped, at the same time, to standardize sound relationships between municipal councils and physicians. A broad program of health services for public assistance recipients was launched, providing these needy persons with a far more comprehensive service than the local municipalities were formerly able to support. In the Swift Current Health Region, some 50,000 people became covered by a comprehensive prepaid medical care plan which gained the co-operation of the physicians in the region and has become the object of study by health leaders from all over the continent.

Provincial grants were soon provided for assisting communities and union hospital districts in the construction of hospitals and health centres, to be supplemented later by national health grants. To cope with the isolation of thousands of rural families, a unique airplane ambulance service was organized. A consultation service,

Dr. F. W. Mott, left, is pictured here shaking hands with Francis Hedley Auld, M.B.E., LL.D., Chancellor of the University of Saskatchewan, at the convocaion ceremony.

**Formerly Chairman, Health Services Planning Commission, and Deputy Minister of Public Health, Government of Saskatchewan.*

to raise the quality of hospital care in scores of small institutions, was set up and has been steadily expanded. In 1947, the Saskatchewan Hospital Services Plan was launched, the first demonstration on this continent of the effectiveness of the compulsory insurance principle in financing health services for a whole population. Its direct benefits in providing a generous volume of hospital care to Saskatchewan people are well known; but I suspect that the indirect influences on over-all health planning in this hemisphere will prove even more remarkable.

And these were not all the achievements in Saskatchewan's health decade. The services of the Cancer Commission were greatly expanded, supporting now the complete cost of cancer diagnosis and treatment, including surgical operations, and introducing here in Saskatoon one of the first radioactive cobalt therapy units in the world. In tune with world-wide developments in rehabilitation, restorative services for poliomyelitis and cerebral palsy were greatly extended through specialized centres. Psychiatric services were extended from the hospitals out into the community through mental health clinics and psychological services in the schools, while at Moose Jaw there is being opened an institution for training the mentally retarded which will be the envy of all Canada. To staff this expanding program, Saskatchewan did not simply bewail personnel shortages, but organized its own special programs for training technicians, psychiatric nurses, general nurses, and health aides. The Centralized Lecture Program for nursing students in ten hospitals was another innovation in remarkable adjustment to the rural situation. Newer fields of public health were tilled in this period, like health education and nutrition. Preventive dental services were incorporated in the regional health programs.

During this period, the vigour of governmental action for better health service did not dampen the enthusiasm of voluntary societies; on the contrary, professional associations and voluntary agencies continued their good work, participating in many of these developments and shifting attention to meet newly recognized needs like arthritis and general rehabilitation of the disabled. Prepayment medical care plans under voluntary auspices extended their coverage.

What Lies Ahead?

With this great record of accomplishment in its first half-century, what lies ahead for Saskatchewan? What rôle has the University of Saskatchewan with its College of Medicine and hospital in the next half-century? Deliberately I made no reference to these institutions in the achievements of the recent past. For while they have been built by the toil and dreams of many, their mission lies in the future. In fact, they symbolize the very essence of the tasks that lie ahead in strengthening the quality of medical and hospital service in this great province.

In all ages, the university has been the guardian and conveyor of the lessons of the past. Today it is also the leader into the future. Far from being the distant ivory tower, this hospital and this school of medicine lie at the heart of Saskatchewan's health services. In them will be found the best of modern science and the human spirit. From them will emanate ideas and demonstrations that will infuse medicine in every village and hamlet.

The tasks and ideals of health service in modern communities are almost an endless universe, touching every aspect of life and society. The breadth of the problem has been sketched in Saskatchewan's Health Survey Report of 1951. In my view, the tasks ahead lie along four main paths and, in each of them, the College of Medicine with its teaching hospital must be a vanguard.

Preventive Services

First of all, organized preventive services in Saskatchewan should be strengthened and their content adjusted further to changing needs. Many thousands still live in territory not protected by a full-time public health service. Public understanding of the values of preventive medicine is still not perfect; and more forthright action by the provincial government may be necessary to complete coverage of the province. Surely, the rural region surrounding the City of Saskatoon should be included in an organized service, along with the City Health Department. Aside from its intrinsic value, such a health region would be essential for effective public health teaching and research at the medical school.

The content of regional health services requires adjustment to the changing nature of today's health needs. While evironmental sanitation, communicable disease control, and child and maternal health work remain basic, new attention is required in the vast sphere of chronic disease. The health officer and the family physician must think out and initiate concerted preventive attacks on lung cancer, heart disease, and other major killers and cripplers. Early case-finding, such as has been conducted for years for tuberculosis, might be applied to other chronic disorders. New approaches are needed to the large and complex problems of accidents on the highway and the farm, in the factory and the home — approaches based not only on mass education but on epidemiological analysis of the problem in relation to predictable subjective and objective factors. Deficiencies in housing, especially in the smaller communities, present health hazards, and the public health movement should join in the battle for improvement. Advancing industrialization and expanding mining operations in the province point up the need for a consulting occupational health service.

The continuing inroads of dental disease are so great that only a preventive approach holds hope. Mass fluoridation of water supplies must be extended more rapidly and ways be found to give optimal fluoride intake to persons not on public water systems. For prompt treatment of dental caries in children, use of special auxiliary personnel under professional supervision, like the dental nurse of New Zealand, might well be explored. Saskatchewan could be the first to establish a training school for such workers in North America.

Finally, it seems to me that the scope of administrative services of the health regions should be extended beyond the sphere of strict prevention into all aspects of social medicine. The training and skills of regional health officers and their staffs should be more effectively utilized by having them play a part in the administration of hospitals and the guidance of medical care programs on a tax-supported or prepaid basis. There are wide opportunities for incorporating preventive service into day-to-day hospital and office practice. Co-ordination of the administration of preventive and treatment services at the regional level would present countless opportunities for enhancing the quality of services to the average person in health and disease. Such broad responsibilities, moreover, would attract a stream of well-trained public health physicians to positions in Saskatchewan's health regions.

All these and other tasks in public health service could profit from leadership and inspiration by the College of Medicine's Department of Social and Preventive Medicine. Largely untapped data from the Hospital Services Plan and various medical care programs, on the other hand, could provide this department with endless material for epidemiological research, on

(Continued on page 76)

The Teaching Clinic and

Tomorrow's Doctor

James Howard Means, M.D.,*
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THE RELATIONSHIP of medical education to general education is very important because all those who care for the sick must also be people in general circulation and in tune with their communities. It seems too that the teaching hospital — the medical school and its teaching hospital, we might better say, because the two are one—represents what we may call the germinative centre of medicine. From it flows new facts, new ideas and new personnel of all sorts: physicians, surgeons, medical investigators, nurses and all the other professional people who are necessary in the care of the sick and in the promotion of health. Also, the university hospital cares for patients itself. Thus the teaching hospital really encompasses what I like to think of as the essential trinity of medicine; namely, research, education, and practice. If these three be sweetly blended, we have one great profession. I think of the teaching hospital as representing the centre of a system of concentric rings and spokes, from which radiate all that has to do with medicine in the broadest sense of that term to the entire community.

It seems to me that Great Britain, in setting up a national health service —and I gather you are doing something similar in Saskatchewan — has been very wise in making the medical school and its affiliated hospital the focus of all medical activity. It was a very sound thing to do and I think that the United States should attempt to achieve the same purpose but perhaps by different methods. In my country with its stupendous conservatism, socially at least,we have to do as best we can with what we have. We must work by private endeavour to a large extent, although as some of the reactionary medical people in the United States seem to forget, we have a good deal of government medicine already. Some of the persons who are most hostile to government medicine, I find, and it rather amuses me, work for Uncle Sam and his great veterans' administration medical system and take his pay quite happily. It does not seem to be quite consistent but then we are told that only fools are always consistent.

The Nature of Medicine

I would like to say a word about the nature of medicine. Medicine has been called an art; it has been called a science; but my feeling is that it is neither the one nor the other but rather a professional calling with specific objectives to be reached by employing any body of human knowledge that is useful. I've been working lately in an engineering school because I had reached the retiring age of the medical school where I had previously worked. I had thought I would become very nostalgic for the old place, but I have not been so at all because I have been too busy. Also, I have gained a broader point of view because of working in this institution which approximates a university, although it started as an engineering school. The engineer, I find, is very similar to the physician. His discipline is not a science but a professional calling with definite human objectives. The engineer needs a general education no less than the physician, so that engineering schools are providing as well as they can for such education. Therefore, I would say that medicine is not a science *sui generis* but that it uses all sciences.

Research in Medicine

Now one cannot do such work exclusively in research laboratories, making use of animals or other non-human subjects of research, because in a laboratory one could never conceive all the things needing study in the field of health or medicine. It is nature who provides the subjects, who raises the questions for the medical investigators to solve. We must have research in hospitals because it is there that nature challenges us with the problems of sick people crying for solution. It is natural, therefore, that we should have research in the field of medicine and it is particularly natural that it should be most concentrated and most intensely pursued in the teaching hospital. It should, however, be done by everybody who has the opportunity to make observations. Sir William Osler said "Observe, report, communicate" — and that is a good formula.

James Howard Means, M.D.

The research spirit should be all pervasive among all those who promote health or care for the sick. Anyone may make an observation of importance provided he has a prepared mind. One of my most beloved teachers was the late Walter B. Cannon, who was Professor of Physiology when I was a medical student at Harvard. Shortly before he died he wrote a little book, really an autobiography, in which he used the word "serendipity". He was very fond of this word. He got it from Horace Walpole, and the point was as follows. It was a story about three princes of Serendip, which is an old name for Ceylon, who travelled about the world and were always making accidental observations. They were smart enough to see the significance of their observations, to exploit them and put them to use to their own advantage. That is what one should do in research — exploit the breaks that God or nature gives you, if you want to contribute to the sum total of knowledge in the field of medicine — but it requires the prepared mind. I think a good example is that of the late Sir Alexander Fleming. I remember hearing him, when he received an honorary degree at Harvard, make this remark — "If my laboratory hadn't been so dirty, I never would have discovered penicillin". But you see he had a prepared mind so that when he observed, in certain old cultures of bacteria which had become mouldy, that there were translucent zones about the colonies of mould, he recognized that the mould was making something that killed the bacteria. The ordinary person would have thrown the cultures out; and although nature had given a hint, it would not have been taken. That is serendipity in his case — I think in its purest form. The point that I would like to make

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is, we all have these opportunities. The nurse can have them. She may observe something that the doctor has not observed, and if she tells him he should heed what she says and try to work out what it is all about. Perhaps he will freeze up and be unreceptive. However, we will hope that doctors will improve in their receptivity also as time goes on. That is one of the aims we must strive for in educating our medical students — they must always be prepared to receive new information even if it is most disastrous to their preconceived ideas.

Research in the area of medicine has to be done, part of it at least, in the wards of hospitals. Often it is necessary, for example, as Dr. Browne has indicated, to collect accurately a 24-hour specimen of urine — a difficult thing to do. It is impossible, as he said, and regrettable that it cannot be done in a general ward. A special research ward is necessary and I hope there will be one in this new University Hospital. I started one (Massachusetts General) in 1925, called Ward 4. It had ten beds then and it has ten beds now but it has a very distinguished history because people like Fuller Albright, Chester Jones, Carl W. Walter, and my thyroid group have done a lot of work in it. It was not the first one of its type— Eugene Dubois had one in Bellevue Hospital which I more or less copied, and Francis Peabody had one at the Boston City Hospital. This kind of facility is necessary in the teaching hospital if the latter is to be a germinative centre sending its influence out to the rest of the medical world. It is necessary to have such facilities and the United States government now has accepted this idea, and has built a 500-bed Ward 4 at Bethesda, Md. Some time it will be full of patients with diseases needing study and it will have enough skilled staff to study them properly. It has about 150 now, but is filling up. As I see it, the one trouble with such an institution is that it is not part of a university. The university juxtaposition is really essential to the very best type of research. The presence of the student always increases this intellectual activity. Students are very alert, they are in the period of life when they do not have inhibitions. They can say what they please, they can ask the most embarrassing questions, and the fact that these questions are raised means that ideas come up, and are not forgotten. For that reason I maintain that the best care that a patient gets is where research and education are both going on. We have no place in America, either in Canada or the United States, for the old type of German "Geheimrath" — medicine, where the professor was next to God and nobody dared question what he said. Something happened to me once which I have always remembered and enjoyed. I had been expounding on ward rounds about a certain action of digitalis and said, "It would be particularly useful here, gentlemen". "Not according to Goodman and Gillman", said one of the students. That took me aback for a moment, but I could see that he was right in bringing up the question. I was not sure that Goodman and Gillman were right, but they may have been. At any rate, my statement was questioned; that is the important thing and that is why the patient gets better care in such a place. I am now going to leave research, which is the first of the trinity I mentioned in the beginning, to consider the role of education in medicine.

Education in Medicine

Education must go on. I am afraid the educational influence will be missed at the clinical centre of the U.S.P.H.S., although there are some very good people there. Education should not be dogmatic, it should be an attempt on the part of the teachers to present general principles and to inculcate them. But more particularly education should stimulate, encourage the asking of questions, and teach students how to think for themselves. We should not concentrate on the past but should present to the students unsolved problems of the present and let them get to work on them. Perhaps they will find the answers. "Always be willing to learn" should be the motto of the doctor of medicine or any other scientific person. As long as he lives, he should continue to think and be ready to throw over what he has conceived as the truth if new evidence comes in to shake it. I want to stress also very strongly that one of the most important things we can do is to train physicians, nurses, or any of the people within the fold of medicine, to recognize their responsibilities and to be prepared to meet them both intellectually and morally. It is not a matter of filling students full of facts and giving examinations in the hope of getting the facts back again. We have to teach students how to carry on in their professional work. Any profession has deep commitments in the field of responsibility. That is why we get medical students, pupil nurses, and students of all the medical skills, to work in the hospital or in the outpatient clinic or in the patient's home or wherever there are health problems, and give them responsibilities in relation to the patient at the earliest possible moment. I do not believe there is anything that has more educational value than making young people take responsibility for another human being. When it is given to them, they like it and they rise to it. They meet it, and in so doing are tremendously stimulated. When I was a student we were given no responsibility whatever until we got our medical degrees. We were taken on Cook's tours in large groups around a ward and shown this, that, or the other thing. We only saw the patient once and had nothing to do with his care. That has all been changed with the current system — in Britain and America at least — of giving the students reponsibility in the care of the patient. That makes medicine come alive for them and excites them. There is no reason why such experience should be concentrated in the university hospital. It can be obtained in the regional hospitals, the health centres or the private physician's office if he is in touch with a proper centre.

The Practice of Medicine

Then, finally, practice — what of the doctor of the future? Medicine is so complicated now and so complex that no one individual can take the whole responsibility for patient care because he does not have all the necessary skills. Therefore, team work is necessary and that should extend throughout the whole practice of medicine, even to the most thinly populated area. Doctors of the future must be organized more and more in teams to provide medical care. Also, the team must have a leader. In the teaching hospital the team will be the visiting physician, the chief resident, the various other residents, the interns, the nurses, the social workers, maybe the occupational therapist, the dietitian, whoever is called to take part in the care of the patient. The team must be integrated and as nearly as possible act as a single individual. Moreover, as Dr. Mott has said, we must have team work throughout an area. I am sure that in Canada you have gone farther in doing this than have we in the United States. Canada represents a very intelligent and stimulating position midway between Britain and the United States. In contrast to some of my countrymen, I think the British system is working very well. We have a more or less chaotic state in the United States while Canada occupies an intermediate position. You are trying experiments, and I would agree that the experimental method must be carried out, as Dr. Esther

(Continued on page 84)

Hospital Finance

under government-sponsored hospital insurance

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AMONG major developments in the past year, the most important, from the point of view for operating hospitals, was the Government's decision not to provide funds for salary rates above those established in 1954.

Some of the newer board members and hospital officials may encounter difficulty in differentiating between government policies and the administration of policies. The amount of funds made available for hospital care and the policies to be followed by the Hospital Insurance Service are a responsibility of the Government. The Hospital Insurance Service, as an administrative arm of government, is responsible for carrying out policies laid down by our board of directors which is known as the Cabinet.

It is interesting to go back and trace the various changes in policy, with regard to hospital costs, since the Hospital Insurance Service commenced its operations on January 1, 1949.

(1) During 1949 and 1950 hospital deficits were made up; hospitals were free to expand services and increase costs. During these two years, hospital salaries and wages (including added staff) increased by $4,700,000.

(2) In 1951 firm budgets were introduced as a result of a government decision that deficits would not be made up. During 1951 and 1952 reasonable increases in services and increases in salaries were covered and the cost of salaries and wages increased by a further $5,000,000.

(3) In 1953 and 1954 the government decided, in view of the continued increase in the cost of operating existing services, that no funds would be provided for added services. However, during these two years, salary increases were covered and by the end of 1954 a further $5,400,000 had been added to wage costs, bringing the total to $24,800,000.

It will be noted that, during this six-year period, wage costs increased by an average of $2,500,000 per year. Less than $1,000,000 per year of this increase was due to added staff for increased beds and increases in the number of patient days.

(4) For 1955 the government issued instructions that the Hospital Insurance Service was to establish budgets on the basis of 1954 salary rates and allow for increments based upon the 1954 wage scales. These increments increased the total salaries allowed by a further $325,000 which, together with the staff required for added beds and increased occupancy, would bring the total approved expenditure on salaries and wages for 1955 to approximately $25,600,000. This increase of less than $1,000,000 in salaries for 1955 can be compared with the average increase of $2,500,000 during the preceding six years. However, actual expenditure on salaries in 1955 will exceed the approved amount since a number of hospitals are paying higher salary rates than those included in their budgets.

Before going on to speak about other matters I would like to bring to your attention a few facts relative to the over-all hospital picture in British Columbia.

It is estimated that the total expenditure by the public hospitals of this province for 1955, will be approximately $37,000,000. This compares with $16,300,000 in 1948 — an increase of over $20,000,000 or approximately 125 per cent in seven years.

In 1954 B.C. hospitals employed 10,700 workers, including 1,285 student nurses. An increase of 700 employees over 1953 was to a considerable extent due to a shorter work week.

In 1954 public hospitals admitted 164 patients for every 1,000 population. This was the same as in 1953. However, since the average patient in 1954 remained in hospital a little longer than in 1953, hospitals provided an additional 50 days of care per 1,000 population. This slight increase in the average length of stay of patients added 60,000 hospital days to the 1954 total.

By December 31st of this year the Hospital Insurance Service will have paid hospital accounts amounting to almost $150,000,000.

Construction

During this year it has been found necessary that pre-construction budgets be submitted by hospitals prior to the approval of construction projects. This additional procedure was brought about by the planning of new hospitals or major additions with insufficient consideration being given to operating costs.

The construction cost of hospitals is infinitesimal when compared with the operating costs that are incurred during the life of the building. We must keep in mind that hospitals being constructed today will probably be in operation 50 years from now, when hospital employees, if present trends continue, may have a shorter work week. Expenditure on building facilities and equipment that will reduce service costs, and enable the hospital to devote a maximum share of its operating funds to the care of patients, is absolutely essential. To do this, it is necessary that the proposed hospital be "staffed" while it is still on the drawing board. Every procedure should be analyzed in detail to ensure efficient and economical operation. The operating estimates for the proposed new hospital or addition should be based upon a reasonable occupancy. Almost any hospital, no matter how poor the plan, could operate at a reasonable per diem rate with a very high level of occupancy. The real test of planning is the hospital's ability to provide care at a reasonable cost for a level of occupancy considered to be normal and desirable.

In connection with these pre-construction estimates, I quote from a recent article of Conrad Hilton, the international hotel man. "Hotel profits today start on the drawing board. Modern hotels and furnishings are easier to keep clean and maintain — a vital factor, for hotel labour costs three times more than it used to, and works eight hours instead of 12 or 16.

From an address presented at the British Columbia Hospitals' Association Convention, Vancouver, October, 1955.

It is necessary to face up to the facts of modern hotel life by installing labour-saving machinery in the kitchens and laundries, et cetera."

One of the problems connected with the construction of hospitals is created by the desire to have sufficient beds to allow for a population increase in the next five, ten or 15 years. This is a reasonable and business-like approach to hospital construction but, in practice, we find that in many areas new beds made available for the future are almost immediately occupied as a result of the average patient remaining in the hospital for one, two, or three days longer. One wonders how much of this increase is necessary and if it would not be better to change the present construction policy to one of planning intensively for the future but building only for present needs. When one considers the relatively small cost of adding bed areas, when compared with the annual operating cost, it would seem that such a policy is inevitable.

Advisory Councils

Another recent development has been the appointment of two advisory councils to make recommendations in connection with the laboratory and radiological services grant which has been made available through the Federal Government. Each of these advisory councils consists of members from the Canadian Medical Association, B.C. Branch; the Faculty of Medicine at the University of British Columbia; the British Columbia Hospitals' Association; the Health Branch and the Hospital Insurance Service. These grants were made available by the Federal Government to assist in the improvement and expansion of laboratory and radiological diagnostic facilities and services. We can assume that this is considered by Ottawa to be a very important prerequisite to any development of health insurance in Canada. To date, these grants have been, generally speaking, restricted to assisting hospitals in purchasing laboratory and radiological equipment on the basis of 40 per cent federal funds, 20 per cent provincial funds, and 40 per cent from the hospital.

These two advisory councils have held a number of meetings during the past two months and are studying existing facilities, staff and services, with the object of making recommendations as to how the funds can best be utilized to assist hospitals in improving their laboratory and x-ray diagnostic services. Hospital administration should keep these grants in mind when considering the development or expansion of x-ray or laboratory services.

Preparing for a Survey

During this year a considerable number of hospitals have requested a survey of their operations or administrative assistance from the Hospital Insurance Service. Some of these requests are as a result of policies in connection with hospital wages and staff numbers. In previous years a few surveys were carried out by the limited staff available to our Service. As the average survey requires considerable time, it is apparent that only a few can be carried out in a year, particularly since the B.C.H.I.S. personnel making surveys have other regular duties to perform. Since it is obvious that all hospitals requesting surveys cannot be visited for some considerable time, I thought it might be of assistance if I outlined (1) the information we consider is required before commencing a survey and (2) steps taken by other hospitals to help control operating costs and conditions found in some hospitals that have been surveyed. In view of the time limit, only a relatively few items can be mentioned. A number of hospitals that have carefully reviewed their own operations report results that indicate considerable success. No two hospitals are identical. It may be that your hospital does not have any of the conditions to which I refer, but these may give you some ideas.

To carry out a survey it is necessary that you obtain certain facts and figures that will enable you to measure volume and activity. We consider that accurate and up-to-date financial and statistical information is a necessary administrative tool and a prerequisite of any survey. Administration cannot control unless it insists on receiving such information, nor can administration plan a future course if the present position is not known. The following basic data should be obtained in advance of a survey.

(1) A detailed comparison, by position and by department, of the staff paid during a current month and during a similar month in a preceding year. One of the objectives of this comparison is to determine where staff numbers, relief staff, and over-time payments have increased. An analysis by departments may indicate areas that should be investigated. Particular attention should be given to increases in the payment for over-time and relief staff. It is, of course, necessary to allow for changes in patient days and the effect of a reduction in work hours.

(2) In addition to the salary information it is necessary that complete inventories be taken of all supplies. A trial balance and financial statements, incorporating these inventory adjustments, should be prepared and compared with the approved budget. When comparing expenditure or supply items allowance should be made for variations in the number of patient-days of care in relation to the approved budget.

(Concluded on page 74)

R. H. Stocker

Administrator of the Western Memorial Hospital, Corner Brook, Newfoundland, since January, 1952, R. H. Stocker began his career in hospital administration in London, Eng., in 1937, shortly becoming manager of a group of privately-owned hospitals in that vicinity. He has been a member of the executive of the Maritime Hospital Association since May, 1952, and was elected president in June, 1955.

J. H. Roy

President of the Montreal Hospital Council since 1937, J. H. Roy, F.A.C.H.A., joined the staff of Hôpital St-Luc, Montreal, in 1915 as controller, becoming superintendent in 1929. At the inaugural meeting of the Canadian Hospital Council in September 1931, Mr. Roy was a delegate representing the Montreal Hospital Council, a role he has fulfilled at many national meetings.

From coast to coast—

Meet the Presidents . . . . . .

next month's issue will feature presidents of Catholic Conferences

Eugene F. Bourassa

Elected president of the Saskatchewan Hospital Association in October, 1955, Eugene F. Bourassa has been business manager of the Regina Grey Nuns' Hospital, Regina, since January, 1951. In 1952, Mr. Bourassa became a member of the executive of the provincial hospital association and was elected vice-president in June, 1953. Last fall, he was selected as a nominee of the American College of Hospital Administrators, at the annual convocation in Atlantic City.

Mrs. Charles McLean

Currently only female provincial hospital association president, Mrs. Charles McLean of Toronto, Ont., was elected president of the Ontario Hospital Association in October, 1955, after serving as a member of the provincial organization's board since 1951. During the past 15 years, Mrs. McLean has been a member of the board of governors of Women's College Hospital, Toronto, having served as president of that board for a period of four years.

Rev. H. L. Bertrand

President of the Comité des Hôpitaux du Québec, Rev. H. L. Bertrand, S. J., began to give extensively of his time to hospital work after service in World War II, as a chaplain. In 1946, he was named president of the Catholic Hospital Council of Canada and held this office until 1952, when he resigned in order to devote full time to the Comité. In 1949, he was elected executive member-at-large of the Canadian Hospital Council, serving on the board of directors for six years.

J. A. Abrahamson

First entering the hospital field in 1935 as a member of the board of management of the Queen Victoria Hospital, Revelstoke, B.C., J. A. Abrahamson has served that hospital for over 20 years. For the past ten years, he has been chairman of the hospital's board. Last fall, he was elected president of the British Columbia Hospitals' Association, after two terms as vice-president.

William Chessor

Vice-chairman of the Lacombe Municipal Hospital Board, Lacombe, Alta., William Chessor has been a member of the hospital's governing board since 1947. Appointed a director of the Associated Hospitals of Alberta in October, 1952, Mr. Chessor became vice-president of the association in 1954 and was elected president in June, 1955, at the association's annual meeting.

John Gardner

In 1926, John Gardner of Dauphin, Man., was elected to the board of governors of the Dauphin General Hospital and has been a member ever since, filling practically every office on the board. Mr. Gardner joined the executive of the Associated Hospitals of Manitoba as a regional director for Dauphin and rose to the office of president of that association in the fall of 1955.

In Preparation for

A National Health Service

Rupert H. Stocker,*
Administrator,
Western Memorial Hospital
Corner Brook, Nfld.

WITH THE probable approach of a national hospital service, how many hospital administrators have given this matter more than a passing thought? What changes will be made? What can the administrator do to prepare both his hospital and himself to ensure the smooth operation of the change?

In this short discussion, I would like to suggest some of the answers to this problem; and a problem it certainly will be. I would also make some suggestions as to actions to be taken *now*. My remarks chiefly apply to the smaller hospital (under 100 beds) which provides the backbone of hospital care throughout Canada and which is, by the very nature of things, the centre of medical treatment in almost every community.

First, let us find out what the present position of hospitals in Canada is and how they have fulfilled their duty to the community in the past few years. I recommend a study of the two memoranda recently issued by the Research Division of the Department of National Health and Welfare, Ottawa, entitled *Hospitals in Canada*, and *Selected Public Hospital and Medical Care Plans in Canada*. These give a very good over-all picture of this position.

It is very interesting to note the enormous increase in admissions and estimated days of care per 1,000 population that occurred in Saskatchewan in the five years immediately following the introduction of the Saskatchewan Hospital Services Plan in 1947. This increase in demand for hospital facilities continued to grow until, by 1953, the last year surveyed, one person in every five was admitted to hospital and, on the average, each person in the province spent two days in hospital during the year. Will this be the pattern in other provinces following the introduction of a free hospital service? I am convinced that it will and that the effect will be more marked in those provinces where there is a dearth of chronic and convalescent hospital beds. The future outlook, to my mind, becomes extremely depressing on reading the section of the memorandum *Hospitals in Canada*, which deals with acute hospital beds. It is shown that in 1953 there was an overcrowding of eight per cent in the nine provinces surveyed. The report states, "It should be remembered, however, that future bed requirements are not static, but will change both in relation to an expanding population and future demand for hospital care. If the current requirement of 3.5 beds per 1,000, population is projected into the future and an annual population increase of 400,000 a year is assumed, Canada will need 2,200 new beds each year, apart from beds needed to replace obsolescent facilities. Furthermore, if upward trends in the per capita volume of hospital care continue, additional beds will be needed to meet the increased pressure on facilities." It is pointed out that in Alberta, Saskatchewan, and British Columbia, the number of acute hospital beds per 1,000 population in 1953 was 7.5, 7.7 and 8.8 respectively.

Now let us take a look at the National Health Service of Great Britain which has been in operation for nearly eight years and see if we can learn any useful lessons.

T. Rowland Hill, M.D., M.R.C.S., F.R.C.P., when speaking at the conjoint meeting of the British Medical Association, Canadian Medical Association, and the Ontario Medical Association, in Toronto last year, said that the National Health Service of Great Britain is using up one tenth of the national income and that hospital services account for three quarters of the total expenditure. Hospitals have had to work on a strict financial budget and, with the constant rise in costs of food, fuel and salaries, it has, in many cases, been extremely difficult to maintain adequate basic services. There has been little money to spare for capital expenditure, extension of services or new building schemes. Again, when delivering the John Tate Memorial Lecture on September 14, 1955, in Middlesex, England, Dr. Hill said that the cost of the National Health Service was now so high that its financial arrangements were constantly in the forefront of political affairs. Such cost was surely one of the most colossal miscalculations ever made. A big contributory factor has been the increasing age of the population which has meant that the service is increasingly being called upon to deal with the degenerative diseases of later life. Following the Beveridge Report in 1948, the note in all discussions had been the economy which would follow due to the increase in the working strength of the people for whom the service would make curative and preventive measures promptly available. Some form of highly competent central control would be necessary if the rapidly rising costs were to be halted and efficiency and economy secured.

Recent correspondence in the *London Times* and the *British Medical Journal* indicates that the relationship between the hospital administration and the medical profession is wholly unsatisfactory. There have been charges of over-centralization and rigid application of a cast-iron system. This is of course all too common in any system where bureaucracy reigns supreme.

In *Hospitals in Canada* it is stated: "In order to provide an efficient hospital service more is required than simply an adequate number of beds, personnel and special facilities . . . The improvement of hospital service is a co-operative effort between the hospitals and government health departments. Leadership comes from the Canadian Hospital Association, the Catholic Hospital Association of Canada, the Canadian Medical Association and various other national and provincial organizations interested in all or certain phases of hospital care. Standardization, education, and surveys are the principal tools used by these various agencies to stimulate hospital efficiency." However, we must ensure that the accusations made against the hospitals in England can never be applied to us. We must realize that administration is not the end in itself, but only a means towards the end, which is the effective treatment of the patient by a team of highly skilled professional men and women.

Sir Hugh Linstead, M.P., a member of the Central Health Survey Council of Great Britain, writing in the *British Medical Journal*, says: "The administrator (ministry, board, group or individual) needs always to remember that his art is the infinite adventure of governing men, which implies, not supremacy, but carrying your colleagues along with you. The doctor faced with a difficult administrator needs to remember that, at the worst, he is only a somewhat refractory patient, to

*The author began his career in hospital administration in England (see, page 46)

New Casualty Hospital, Vienna, Austria

Austria is proud of her post-war hospitals and has built more new ones since the war than any other country in Europe. The newest one, pictured above, is a casualty hospital located in Vienna. The 240-bed institution was begun in 1952, and cost some £960,000 to build. It will have five operating theatres, each of which will contain £7,000 worth of equipment. A spacious basement swimming pool for hydrotherapy is one of its main features, while wards will contain no more than six beds.

Austrian planners figure on about £4,000 per bed for a really up-to-date hospital. Others built since the war include those located at Linz, Salzburg, and Klagenfurt. The site for the Salzburg hospital was blasted out of the solid rock of a mountainside, accounting for its high cost of £5,600 a bed. Vienna's city fathers are now planning for a new 2,000-bed hospital, which will take six years to build at an estimated eight and a half million pounds.

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be reasoned with until he can be made to see sense and perhaps even to laugh at himself."

How should the individual administrator approach the problem now? He should first make an introspective survey of the operations of his own hospital and compare them with the Canadian averages given in the memorandum, *Hospitals in Canada*.

Among the various aspects of these hospital operations that will require special study, the following are suggested:

Staff Requirements. How close do your standards approach those suggested in the *Hospital Nursing Service Manual**? Have you considered how your staff could operate if your occupancy were permanently close to 100 per cent?

Business Administration. Have you adopted the *Canadian Hospital Accounting Manual*? Does your fiscal year correspond to your provincial fiscal year? Do you operate depreciation accounts properly? How are reserve funds and endowments, debentures and loans secured and how will you operate them in the future?

**Prepared by the American Hospital Association and the National League for Nursing*, 1950.

Your Hospital and the Law. Since the beginning of the National Health Service in England, there has been a noticeable increase in claims and legal proceedings against hospitals and their staffs, particularly the medical staff. There is no evidence of deterioration in the standards of care renddered; but the increase in legal action is generally attributed to the disappearance of the old friendly feeling towards the hospital. It is no longer a question of withholding a complaint against "our hospital". The impersonality of "the state" has no feelings to be hurt. Is your hospital adequately insured? Is it a requirement that each one of your medical staff be a member of some recognized medical protection society?

Purchasing Department. How are your stocks? How do you purchase, from local retail firms or by yearly contract? Does any furniture or equipment need replacing? Adopt a "do it now" policy.

Ladies' Auxiliary. Discuss with your auxiliary what their position will be when free hospital service is given by your hospital. Will they still wish to continue with their work? Will their cause still have the same appeal to the community?

Finally, try to organize a free and frank discussion with all the medical staff, with the object of trying to lay down some sort of policy regarding the control of admissions and types of cases to be treated in your hospital. Co-operation between all the members of the medical profession in your community and your hospital will be of vital importance if you are to fulfill your duty to the community properly.

Under the British National Health Service, the very serious nature of the hospital problem at the present time is not understood by many. The overcrowding that exists in every hospital and the very long waiting period for elective treatment is due to the number of unnecessary cases sent for both in-patient and out-patient treatment to the hospitals. Far more cases could be treated at home and so relieve hospital beds for those cases which really need hospital treatment.

A proper appreciation of the situation that is approaching us all will help to overcome most of the obstacles before they arise. Whatever form the future health service takes, the attitude "it will never work" is purely destructive. It *must* work and the hospital administrator is the person upon whose shoulders will fall the duty of making it work. ●

A Tribute to Malcolm T. MacEachern

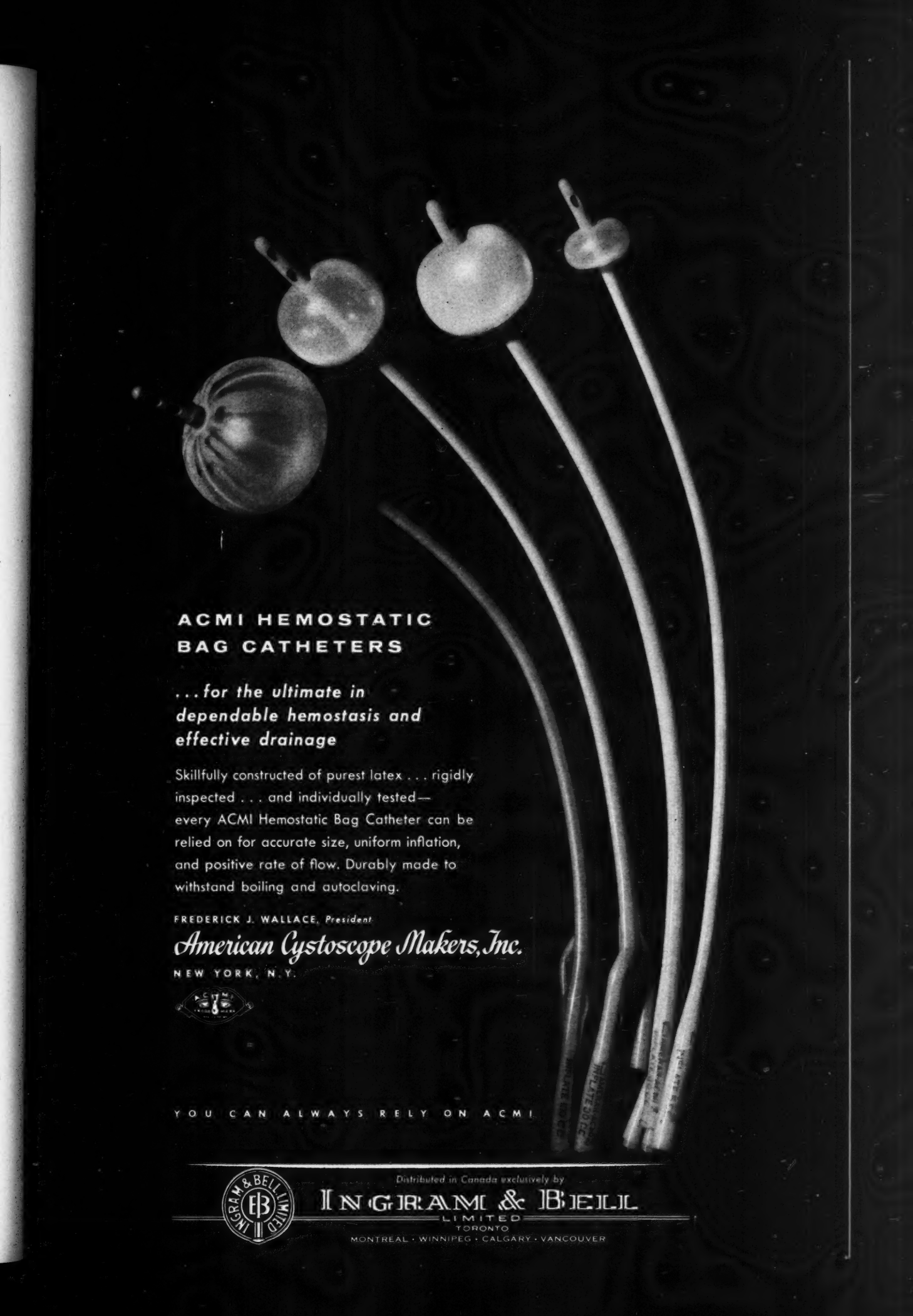
THE RECENT death of Dr. Malcolm T. MacEachern, in Chicago, closes the career of the man who has made more contributions to the development of hospitals throughout the world than any other individual. Only time will really reveal the extent to which this great leader has influenced the progress of medicine. Dr. MacEachern has been a world figure in the hospital field for nearly four decades. He was responsible for the greatest single factor in setting the present high standards for hospitals on this continent—the standardization program of the American College of Surgeons, a function now assumed by the Joint Commission on Hospital Accreditation. Only those who knew the battles fought in the 20's and early 30's can appreciate the struggle necessary to get this program started. Some will recall the mammoth public meetings and the crowded hospital conferences. He was responsible for the development of countless improvements in hospital procedures and in basic organization. In every province and every state, and in many other countries, he preached better records, better controls, and better training of personnel. He organized the accreditation program in Australia. At Northwestern University in Chicago he organized and directed the largest graduate school in hospital administration in the world. His textbook, *Hospital Organization and Management,* is the bible of hospital administrators everywhere.

A prodigious worker, normally rising at five in the morning and, when working under pressure from publishers and editors, rising at 4:00 a.m., he accomplished more in his lifetime than would be considered the commendable joint achievement of at least three busy people. He was a frequent guest lecturer in South America. He was a past president of the American Hospital Association and was the first recipient of its Award of Merit. He was president of the International Hospital Association at the outbreak of World War II. He gave the initial impetus to setting up a code of hospital ethics. For years he was chairman of the credentials committee of the A.C.H.A. In practically every worthwhile development in the hospital field on this continent, during the past 35 years, Dr. MacEachern has been an active, and often the central, figure, and always he was kindly and diplomatic, never seeking things for himself but always trying to help others.

With all his international activities Dr. MacEachern never forgot the country of his birth. He seldom missed a Canadian hospital or medical convention and befriended and helped hundreds in the medican and administrative fields. As an ambassador of Canadian goodwill and achievement, he had no peers. Literally thousands across this country knew and loved this kindly and inspiring man and will deeply regret his passing. In the words of the poet Longfellow:

"So when a great man dies,
For years beyond our ken
The light he leaves behind him lies
Upon the paths of men."

—Harvey Agnew, M.D.



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In a changing population

Changing Health Problems

Robert Kohn, M.A., Ph.D.,
Chief, Public Health Section, Dominion Bureau of Statistics, Ottawa.

THERE ARE many factors affecting the health of the individual as well as of the community. Progress in medical science and its availability to wider groups of the population have contributed to the control of disease and to the improvement of health. Better sanitation and higher standards of living likewise help to prevent illness and facilitate its cure. Other factors, however, are working in the opposite direction. Our extended life span means more chronic and degenerative illness. Modern technology has brought about many blessings, but also new hazards. The large increase in cancer of the respiratory system among men, for instance, is generally ascribed to man-made changes in our environment or habits. There is some speculation as to the long range effects of radiation resulting from the use of atomic power, effects which, unless checked in time, may in the end offset the usefulness of isotopes and cobalt bombs. In the planning of health services, however, future developments of that kind can hardly be taken into account because we cannot predict new discoveries and their effects.

More amenable to evaluation, however, are certain results upon the nation's health problems from changes in its demographic characteristics. There is a very close inter-relation between health and population size and structure. Mortality is, together with birth rate and migration, a chief factor in determining the number of people and their age distribution. On the other hand, there are many characteristics of the population which will have an effect on the state of health of a community and the country as a whole. The distribution between rural and urban areas, the size of the community, housing, occupation, income, education are all bound to influence health and the use people make or can make of health services. These brief notes can deal with a few basic demographic implications only: those of the size of the population and its age composition. Neither one of these factors will, in itself, make for any qualitative changes in the state of the nation's health but both have a very marked effect on the volume of illness and on the resulting demand for health services.

From the results of the Canadian Sickness Survey we have a fairly good idea of the amount of illness among Canadians around the year 1951. We do not possess comparable data for other years but applying the rates obtained from that survey to various populations, past and future, will give some idea of what changes have occurred and will occur in the future merely due to changes in the population, leaving aside all other influences whose effects would in any case be hard to predict.

For one thing, an increase in the population will mean an increase in the volume of sickness in the country. Without any increase in sickness rates or even despite a reduction in the rates, a substantial increase in the number of people will bring about a greater number of sick people and hence a growing demand for health services.

More people means more sickness and, in turn, a higher demand for health services. In 1951, the year the Canadian Sickness Survey was held, Canada's population was about 14 million. It was over 5 million in 1901, and about 11 million in 1941. Estimates are that by 1971 the number will have risen to somewhere around 22 million. In other words, in 1951, the number of potential patients was about three times as high as fifty years before; it was, by about one-fourth, higher than it had been only ten years previously; and it will be about 50 per cent higher again twenty years later, in 1971. That sounds like simple arithmetic that would make it fairly easy to predict the need for health services. It does, in fact, give a fairly good indication of the demand we may expect at some time in the future but it is not quite as simple as forecasting, for instance, the need for schools. A certain number of school children will always require a certain number of classrooms, by and large, without regard to any change in educational methods. The demand for hospital beds, on the other hand, depends not only on the number of patients but may also be very substantially affected by new treatment methods, such as new drugs, and by alternative ways of providing the services, such as home care. The fact remains, however, that it is not enough to bring the supply of personnel and facilities up to what is recognized as an adequate standard today but that we must plan for further expansion to keep pace with the growth of the population.

The volume of sickness in the community depends not only on the number of people but it varies a good deal with people's age. The Sickness Survey supports what we have known from other more limited studies, that the amount of sickness increases with age, not to speak of the fact that causes of illnesses among the aged are of a type different from that generally prevalent among the younger people. With the general growth of the population the number of older people has, of course, increased too. If we just take the over-65 group, their number has grown from over a quarter of a million in 1901 to over one million in 1951. Even over the ten-year period only between 1941 and 1951 the number rose by about 300,000. But not only have the older people increased in number, they also form a greater proportion today of the whole population than they did ten or twenty years ago. In 1951 they accounted for 7.8 per cent of the population, compared with 6.7 per cent in 1941, and 5.1 per cent in 1901. Although an over 50 per cent increase in the percentage, it does not strike us as too important because of the small figures. But it does assume greater significance if we consider that we have today over 370,000 more people in the over-65 group than we would have if their proportion had remained the same. A process of aging has been going on even within this age group, accentuating the problem.

Thus, a larger population also means more older people and hence a greater requirement for health services. If, as has been the case in recent decades, this age group increases not only in number but also in its proportion to the total population, the problem becomes still more urgent. The increasing proportion of older people alone would have caused the average days of disability per Canadian per year to rise from 11.2 days fifty years ago to 11.9 days today. The average days of any illness, light or severe, would have risen from 47.7 to 51.4. These are seemingly small changes if we look at the individual person but for 15 million people it means an extra 10 mil-

(Continued on page 90)

Reprinted from "Canada's Health and Welfare", February 1956.


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Onions in the Stew?

Doris Montalbetti,*
District Home Economist,
Westlock, Alta.

MY THANKS and apologies to authoress Betty MacDonald for suggesting a title to introduce a subject related to dietetics. Actually "Onions in the Stew?" might well be the first question to greet the dietitian as she prepares to accept the challenges of what promises to be a bright and busy day.

The first stop in the morning is the diet kitchen. Although it seems that the modern trend is to abolish this part of the dietary department, we find it the best organization for our set-up. For the most part, all the food served from the diet kitchen is prepared in the main kitchen. However, due to the small numbers of certain special diets, we find it advantageous to prepare a few dishes here, *i.e.*, salt-free vegetables, fat-free soups, and salt-free stews. Hence, after bidding the time of day, one of the girls might salute me with "Onions in the stew?" —and so the day begins.

Now, after the menu has been checked, would you like to journey with me to the formula room, where I hope we will find the student nurse beginning the preparation of formulas? After going over the day's list, checking methods and supplies, let's have a look at the state of the autoclave. Because this is one of the most dangerous breeding places for bacteria, we are always as concerned as the inspectors about high standards prevailing in our infant feeding preparation centres.

From here we take our leave to join the main kitchen staff and stop the wheels of industry for a chat with the chef. The menu for the day is gone over, standard recipes checked, changes, if any, made, the refrigerator toured quickly, and wise use of leftovers discussed. On the way out, we are apt to be met by a well-meant, animated individual who proceeds to forecast the potato market for the coming year with the authority of an economic statistician. Would we be interested in stepping outside and looking over his supply of potatoes, his price being cheaper than that of any wholesale in town? Five or ten minutes later, having assured him that our stock is fine, we're on our way back to the office. Here we attend to requisitions for new diets. Copies of diets are mailed to those eager patients who might have left the previous day without them. If it happens to be the day for local grocery ordering, then off to the telephone and a bit of dickering.

Now, with the diet lists clutched determinedly in hand, we set off for the floors. Here we slip in to see the patients; sometimes to soothe and convince them as subtly as possible that the diet restrictions are not to be taken as a personal punishment but have as much therapeutic value as any medication or pill. Then, of course, there are always the types who fancy themselves to be in some luxurious hotel — these present the biggest challenge of all. Generally speaking these people aren't accustomed to such fanfare at home. I think the answer to this problem is the selective menu. This way the patients have a choice and know what they are getting. Many times we send up a tray and if the food is strange to the patient it won't be touched regardless of the merit of the dish. When the patient's appetite and spirit of adventure with regard to food are dulled he is more satisfied with plain or at least familiar foods.

The patient himself is the only one who knows if he prefers one or two slices of bread, brown or white, double or small servings, beef or lamb, and, if he has a chance to say so by marking his own menu, he is going to eat what he gets and be more contented. Don't overlook the suggestive and persuasive power of the nurse in this matter. Co-operation here is important, *i.e*, getting the menus marked and sent down for set times, with perhaps a word of encouragement to the patient to choose more if he hasn't much marked for the next day.

Then there is the diet list to be checked by the supervisor. We use this system of keeping track of all the patients, the type of diet they are on, and recording instructions like "held trays", "push fluid", and so on. The night staff write up the sheet and send it down before breakfast and it is checked before dinner and supper for changes. This type of diet list is essential with the selective menu.

By the time we make our way back to the kitchen, dinnertime has sped around. There are trays to be checked and 120 patients waiting for an appetizing and satisfying meal. One important detail is to serve hot foods hot and cold foods cold — the greatest problem with centralized service. This is met, in my opinion, by attention to efficiency along the conveyor belt and a bright, fast delivery crew. The crew should be part of the kitchen staff; it is false economy to have professional staff passing trays.

With dinner over, preparations for the next meal begin. The student nurse must be instructed in diet therapy and together we discuss problem patients and prepare some of the special diet suppers.

The afternoon is generally occupied with lecture planning, calculation of special diets, menu planning, work schedules, and time sheets. Just when we get carried away with Almond Delight, a smiling face presents itself and it turns out to belong to an agent, salesman, traveller (call him what you will) from the "A Plus Food Foods Inc." He has the fastest, easiest, tastiest, most economical soup base on the market and a repartee to go with it.

If we are lucky we'll tear ourselves away in time to check the goods which arrived that day. Things come to us in many ways; sometimes they were meant for someone else; sometimes their quality is questionable; sometimes they are damaged en route; and sometimes they are meant for us and just what we ordered.

Finally we are back and the supper trays are on the way up. We are at the beginning of the end. We've just had a glance at one dietary department. My hope is not that I have solved any of your particular problems but that I have contributed to a meaningful view of that department which looks after purchasing, production, and service of food in your hospital. ●

Food Service

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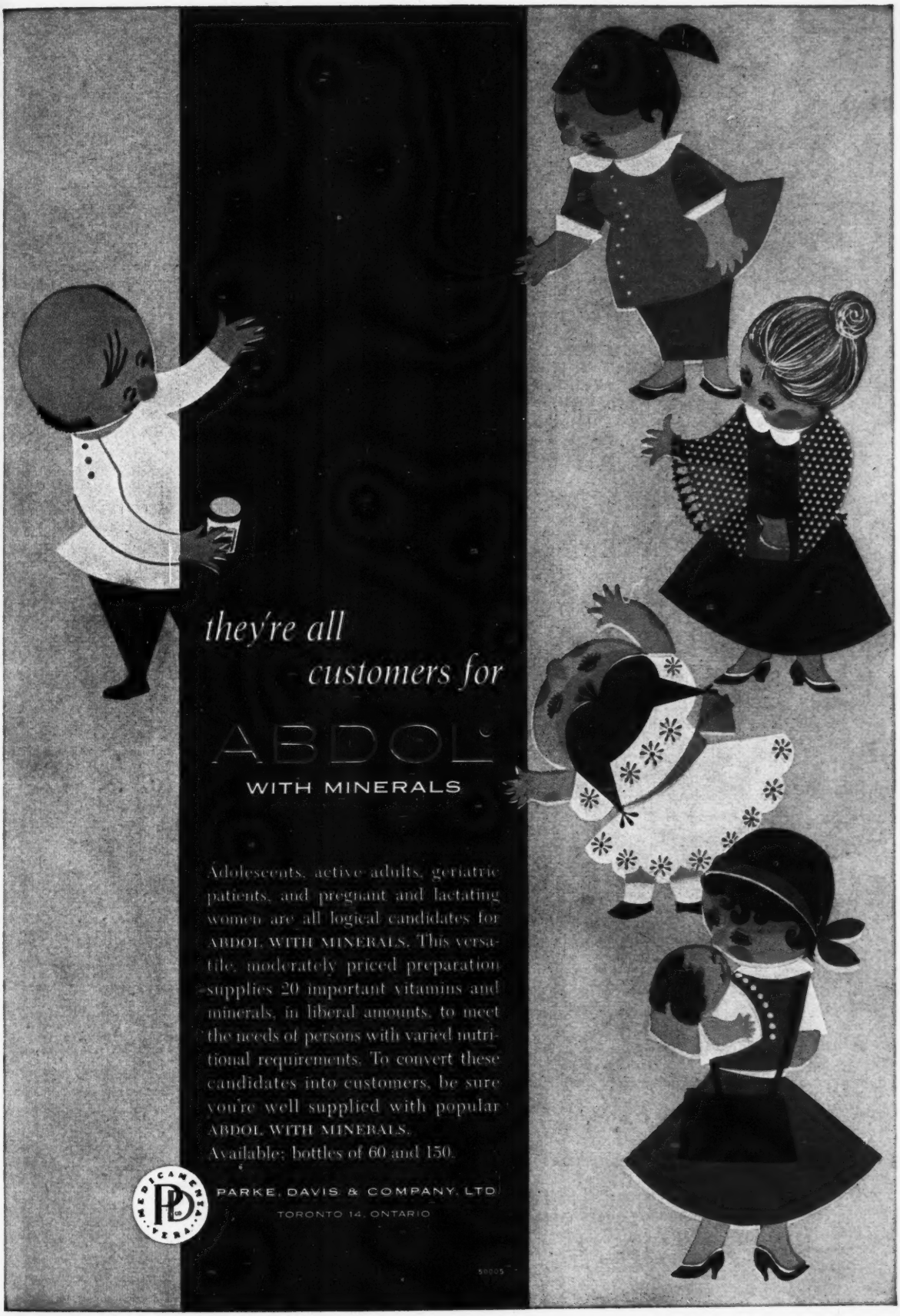
**Miss Montalbetti was formerly dietitian at St. Joseph's General Hospital, North Bay, Ont., and this article is condensed from an address presented at a meeting of the Central Regional Council No. 11 of the Ontario Hospital Association, Sudbury, September,* 1955.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Book Reviews

AN INTRODUCTION TO MEDICAL LABORATORY TECHNOLOGY. By Baker, Silverton and Luckcock, Brompton Hospital, London, Eng. Pp. 330. Illustrated. Price $6.00. Published by Butterworth & Co. Ltd., London, Eng. and Toronto, Ont.

F. J. Baker, F.I.M.L.T., F.R.M.S., is the chief technician, R. E. Silverton, A.I.M.L.T., F.R.M.S., senior histology technician, and Eveline D. Luckcock, A.I.M.L.T., senior biochemistry technician, all of the Department of Pathology, Brompton Hospital, London, England. The authors have drawn from their wide personal experience in training student technicians at the Brompton Hospital and the book presents practical knowledge as well as a sound theoretical background. It consists of five separate sections: general, chemistry, histology, bacteriology, and haematology, and contains, in addition, an appendix, bibliography, glossary and index. A number of proved techniques are also presented.

The last quarter century has seen a great increase in the number of medical laboratory technicians and this book has been prepared to meet their needs. While primarily intended for those preparing for the intermediate examination of the Institute of Medical Laboratory Technology in England, it will prove a very useful book for Canadian students preparing for similar examinations in Canada. — *W.D.P.*

FROM CUSTODIAL TO THERAPEUTIC PATIENT CARE IN MENTAL HOSPITALS. By Milton Greenblatt, M.D.; Richard H. York, Ph.D., and Esther Lucile Brown, Ph.D. Price $5.00. Pp. 497. Published by the Russell Sage Foundation, New York, N.Y.

Milton Greenblatt, M.D., is psychiatrist in charge of research laboratories, Boston Psychopathic Hospital; Richard H. York, Ph.D., is clinical psychologist at Boston Psychopathic Hospital; and Esther Lucile Brown, Ph.D., is Director of Studies in the Professions, Russell Sage Foundation.

In an era where there is a marked awakening on the part of the public, departments of health, and health leaders, to the whole question of patient care in mental hospitals, this book describes the principles and practices of patient care evolved by one of the advanced teaching and research institutions concerned with mental illness, Boston Psychopathic Hospital. It reports, also, on experiments in improving patient care undertaken in two much larger state and federal institutions.

The primary aim of the authors is to stimulate more immediate and direct interest in the improvement of mental patient care. The first section of the book traces the rapid evolution of concepts and practices in the care of the mentally ill in recent years at Boston Psychopathic Hospital, a hospital which, for the most part, treats acute cases of psychosis. This section is a chronicle of the experience of an institution which for more than a decade has explored ways and means of improving the care of the mentally ill through more effective use of the physical and social environment of the hospital.

Discussion of the ward care program outlined in part I of the book is essentially based on developments after the year 1943. The book traces the change in the attitude of personnel who found that patients could rise to surprising heights of self-respect and acceptable behaviour if encouraged by opportunities made available at strategic points in their recovery curve, and by a ward atmosphere where progressive assumption of responsibilities was the rule. When it appeared that by changes in the environment and in social expectation patients might be led step by step to higher levels of achievement, creativity and motivation were greatly stimulated. As the challenge began to unfold, the staff became more sensitive to the many ways in which rigid hospital routines, thoughtlessly accepted as good practice, might prohibit or retard the growth of patients. The more alert members of the staff offered suggestions for improvement which were often eagerly accepted for trial. Thus began the release of imaginative suggestions from the ranks of personnel.

Parts II and III comprise Dr. Richard H. York's report on improvement of patient care at Bedford Veterans' Administration Hospital and Metropolitan State Hospital, where primarily chronic patients are cared for in large numbers. What has been learned in all three institutions through study of the hospitals' social systems and analyses of ward care and direct experiments has wide application to the institutional treatment of mental disorders.

We are facing an expanding problem of mental health care and in this field shortages can be seen in every respect. It is heartening, however, that in the past decade or so there are encouraging signs that we are on the road to more enlightened and responsible care of the mentally ill. Certain general principles of social treatment are emerging. In many respects, these principles are not unlike those of the moral treatment of the 1830's; in fact, as the authors point out, they may be viewed as a reinterpretation of such treatment in the language of contemporary concepts that are being evolved by psychiatry and the behaviour sciences.

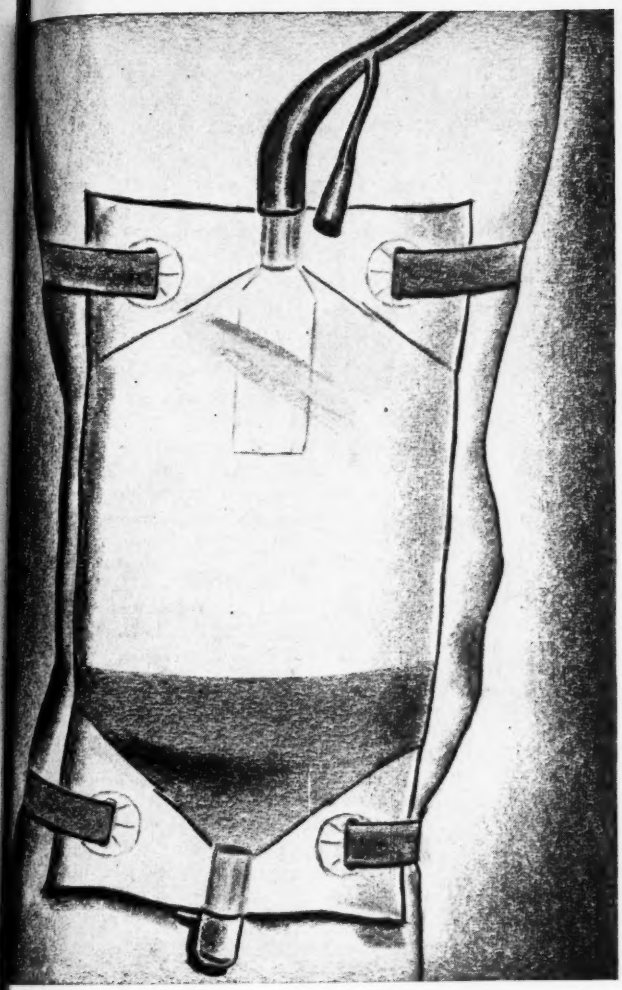
This is a book which should be read by all who are concerned with patient care. It is one we would like to see read by general hospital people whether or not the hospitals have psychiatric wards, because what was accomplished at Boston Psychopathic Hospital with regard to staff attitudes to patients has more than passing implications for all hospitals. — *W.D.P.*

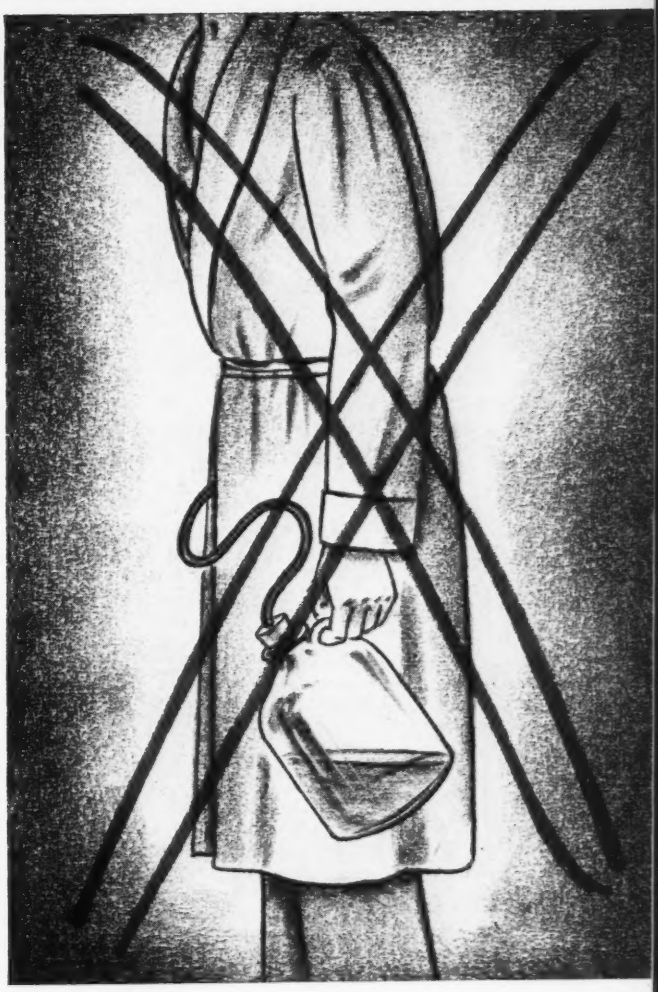
THE GIVE AND TAKE IN HOSPITALS; A STUDY OF HUMAN ORGANIZATION. By Temple Burling, M.D., Edith M. Lentz and Robert N. Wilson. Pp. 355. Price $4.75. G. P. Putnam's Sons, New York, 1955, published in Canada by McAinsh & Co., Ltd., Toronto.

This report on research initiated by the American Hospital Association and conducted by the Cornell University School of Industrial Relations is aimed at clarifying the problems of supervisory training and employee motivation in the hospital. By all odds, it is the most substantial contribution of our day to this ancient but relatively unexplored area of administration.

Throughout the hospital there has been a long and insistent cry for greater understanding. Nurses want understanding from the physician, the administrator and all other hospital

(Concluded on page 110)





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With the Auxiliaries

Trail Auxiliary Active

Patients large and small at Trail-Tadanac Hospital, Trail, B.C., really appreciate the work of the hospital's auxiliary. For the younger patients, there are the "play ladies" who come in and entertain them regularly — reading, chatting, and playing games. The older patients take a great deal of interest in the library cart which is run by the group. It is kept supplied through donations of books and the latest magazines.

• • • •

Auxiliary Finds Drama Profitable

The women's auxiliary to Douglas Memorial Hospital, Fort Erie, Ont., has found that sponsoring dramatic productions is an excellent means of raising funds. This year they have already sponsored an operetta, Victor Herbert's "Babes in Toyland". Last year it was a play, "Young Wives' Tales". Other projects which the group has found successful are luncheons, baked goods sales, and an annual gift day and tea.

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N.S. Auxiliary Busy in '55

The annual report of the women's auxiliary to All Saints' Springhill Hospital, Springhill, N.S., showed an active and profitable year. Among the group's major projects was covering three ward floors in linoleum and remodelling the hospital's kitchen. The auxiliary ended the year with over $1,200 in the general fund, and another $1,177 in the memorial fund.

• • • •

31st Annual Meeting

The Winnipeg unit of the ladies' auxiliary to Shriners Hospital for Crippled Children, Winnipeg, Man., has reported a very successful year. Various articles of equipment were purchased for the hospital, including a gestetner machine. During the year sewing-room workers mended a total of 5,859 articles, while 114 new articles were made.

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Windsor Group Reviews Year

Mrs. Charles McLean, president of the Ontario Hospital Association, was guest speaker at the annual meeting of the auxiliary to Metropolitan General Hospital, Windsor, Ont. The group's projects during the past year were also reviewed at this time. Among the most successful ones were a "career day" tea for student nurses, a rummage sale, and a country fair. Over $5,000 was raised in 1955 through such projects.

• • • •

Auxiliary Donates $3,000

The women's hospital aid to Saint John General Hospital, Saint John, N.B., recently contributed $3,000 towards the furnishing of the hospital's new nurses' residence. The proceeds of two teas helped to make up the donation. On a Jelly Day sponsored by this group, more than 1,000 jars of jam and jelly were collected for the hospital.

• • • •

Gift Shop to Be Expanded

The auxiliary to Women's College Hospital, Toronto, is planning to expand its gift shop when the hospital's new wing, now under construction, is opened. The shop netted a total of $1,062 for the hospital in 1955. At the auxiliary's annual meeting a new junior auxiliary of 25 members was welcomed into the group. Among its other recent projects was the 23rd annual "January Nite", proceeds from which will be used to furnish a ward in the new wing.

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Auxiliary to have Busy Year

Members of the auxiliary to Dryden District General Hospital, Dryden, Ont., are looking forward to a busy 1956. The group have set themselves a goal of $3,000 to be raised during the year through such projects as telephone parties, fashion show, membership drive, and a cook book sale. Last year almost $2,000 was realized through the sale of cook books.

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Anniversary, Tea, Tag Day

Many busy hours of service were spent in 1955 by the women's auxiliary to Leamington District Memorial Hospital, Leamington, Ont. The group celebrated its fifth anniversary, held a garden tea in June, and a tag day—plus many other activities. One of the auxiliary's more recent projects has been a tuck cart which has proved very successful in its first weeks of operation.

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Yukon Auxiliary Meets

The women's auxiliary to Whitehorse General Hospital, Whitehorse, Y.T., held a busy meeting recently. Officers for the coming year were elected and a work session took place. Seventeen members were present.

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Manitoba Group Has Good Year

A total of $5,086 was raised during 1955 by the members of Fox Memorial Hospital Auxiliary, Carberry, Man. Such projects as an anniversary tea, a rag sale, and Fair dinners helped to raise this sum and supply the hospital with many needed items.

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Annual Meeting

The ladies' aid to Wawanesa and District Memorial Hospital, Wawanesa, Manitoba, held its annual meeting in January, and a bank balance of over $780 was reported — a considerable increase over the preceding year. The group was able to donate many useful articles to the hospital in 1955, through such projects as a pantry shower, catering at the Christmas Banquet, and sponsoring a play, "Papa Is All". The latter grossed about $800 for the auxiliary.

• • • •

New Alberta Group

An auxiliary to the Drumheller Municipal Hospital, Drumheller, Alta., has been organized and held its first meeting recently. Mrs. E. Wershop, president of the provincial hospital auxiliaries organization, was present for the occasion. One of the group's first projects has been the reorganization of the hospital library.

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Oakville Women Pledge $20,000

The members of Oakville-Trafalgar Memorial Hospital's women's auxiliary in Oakville, Ont., have set themselves a real task — $20,000 for the hospital's extension fund. Their objective for 1956 is $5,000, and they hope to have the rest within four years. The money is to go toward equipment and furnishings for the gift shop and canteen which they will run in the new wing, currently under construction.

• • • •

Small Group Does Big Job

Various projects in the year 1955 netted about $3,660 for the Kings County Memorial Hospital Aid, Sussex, N.B. During the same period the group donated some $2,890 in gifts and services to the hospital — a big record for so small an auxiliary.

Provincial Notes

New Brunswick

MONCTON. A new 120-bed nurses' residence is being planned by Moncton Hospital and construction is to begin this summer on the structure. It will accommodate both student and graduate nurses and will cost approximately $600,000. The two-storey residence will be connected with the hospital by a passageway and, in addition to double and single rooms, will contain classrooms, as well as teaching, and recreational facilities. Architects Mott and Myles of Saint John have designed the structure for future expansion. At present the nurses are housed in the old hospital, which was replaced by a new building a few years ago.

Quebec

MONTREAL. Three thousand volunteer workers opened the Joint Hospital Fund campaign for $7,000,000 in January. The money will be used by three of McGill University's four teaching hospitals: Royal Victoria Hospital, Montreal Children's Hospital, and the Royal Edward Laurentian Hospital. All three hospitals are undergoing or planning extensive building and renovation programs which are needed to meet the needs of the city's expanding population.

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MONTREAL. Construction on the new Hôpital Ste-Justine, begun in 1951, is now well over the half-way mark. Cost of the 860-bed children's hospital has so far reached over $16,600,000, and is expected to cost another $5,000,000 before the building is completed. Several departments are expected to begin operating in the new building this year.

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MONTREAL. About $3,500 was stolen from a safe in the Jean Talon Hospital here in January. The thieves were believed to have entered the hospital by an unlocked rear window. A considerable quantity of drugs, which were stored nearby, were left untouched.

MONTREAL. The old Montreal General Hospital buildings on Dorchester Street have been purchased by Cardinal Leger for $1,500,000, it was announced recently. The Brothers of the Order of Hospitaliers of St. John will operate one of the buildings as a home for aged and chronically ill men. It is expected that eventually it will accommodate 500 men, and will be known as the St. Charles Barromee Hospital. Other buildings will be turned over to religious communities, while one will be used for a social service centre.

Ontario

ATIKOKAN. Atikokan General Hospital is making plans for a 20-bed addition. The hospital has been seriously overcrowded and in December had an occupancy rate of 112.9 per cent. A campaign for funds is to be undertaken for the new project, which is expected to cost in the neighbourhood of $150,000.

• • • •

LONDON. Work has begun on a fifth-floor addition to St. Joseph's Hospital's east wing. Designed for interns' quarters, one section of the addition is to be set aside for women interns. When completed next summer it will provide 31 single rooms, lounge, and snack room. Architects for the structure are Watt and Tillmann, London.

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NEWMARKET. A new home for the aged opened here in February, although an official ceremony will be held in May. A name for the $1,500,000 institution had not yet been decided on at the time of opening. A fleet of ambulances transferred more than 50 aged persons requiring special care to the home from Toronto's Lambert Lodge. A living-in staff of 55 will be required to operate the institution.

• • • •

OAKVILLE. Opening of the new 20-bed wing to Oakville-Trafalgar Memorial Hospital has been set tentatively for June, and a power plant in the addition has already gone into operation. Construction on the $1,747,000 wing began last summer.

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PENETANGUISHENE. Construction of a 150-bed wing to the Ontario Hospital will be undertaken soon by the provincial government. The addition will double the size of the hospital's unit for the criminally insane, which was built in 1932. It is expected to cost well over a million dollars. Plans for the extension were first announced in the provincial budget a year ago.

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SOUTHAMPTON. Plans for a 12-bed addition to Saugeen Memorial Hospital are now under consideration. The increase in space is necessary to relieve conditions of overcrowding at the hospital. Cost of the proposed wing is estimated at $75,000. It will be constructed on the west side of the present 26-bed hospital.

• • • •

TIMMINS. Construction is expected to begin soon on a new addition to St. Mary's Hospital here. Cost of the L-shaped wing has been estimated at one million dollars. When this addition is completed, the older portion of the present hospital will be torn down and replaced by a new structure. The complete new hospital will then be in the form of a square. Brais and Savard, Montreal, and Rudolph Papanek, Timmins, are the architects.

• • • •

TORONTO. A new 62-bed wing at Doctors' Hospital was opened officially in January by Hon. Mackinnon Phillips, M.D., provincial minister of health. Four brothers, all doctors, purchased the original hospital in 1952 from the Anglican Sisterhood of St. John the Divine, who had operated it since 1886. It was opened in 1953 and with this latest addition becomes one of the largest private hospitals in Canada.

Manitoba

WINNIPEG. When patients and staff at Children's Hospital move into their new quarters, which are expected to be completed this year, the present hospital is to be converted into a home for the aged. The building has already been purchased, for a reported $250,000, by the Ukrainian Congregation of the Sister Servants of Mary Immaculate. The Ukrainian Sisters will operate the home, which will

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be expanded eventually to accommodate 250 persons. The new Children's Hospital is now under construction.

* * * *

WINNIPEG. Plans are now being considered for a 60-bed wing to be added to the Salvation Army's Grace Hospital here. It is to be a five-storey addition, with the first three floors providing maternity wards. The remaining floors will be used for delivery rooms, medical facilities, and laboratories. Cost of the building will be around $1,250,000. Sketch plans are in the hands of architects Moody and Moore of Winnipeg. It is hoped that construction can be started on the unit this year.

* * * *

WINNIPEG. A contract was awarded recently for construction of the new main wing to Winnipeg General Hospital. The seven-storey extension will connect the hospital's east and west wings, and was designed by Winnipeg architects Moody and Moore. The contract is valued at $4,209,270, the lowest of five bids received.

Saskatchewan

LAFLECHE. Tenders for construction of the new eight-bed LaFleche Hospital building were called recently. The structure is expected to cost about $140,000. The present hospital building has a 14-bed capacity; but facilities must be expanded to cover an enlarged hospital district.

* * * *

WYNYARD. A former Royal Canadian Air Force building is to be converted into a nurses' residence for Wynyard Union Hospital. The residence will accommodate ten nurses and the project is expected to cost some $25,000.

Alberta

BANFF. Construction is expected to begin this spring on a new mineral springs hospital here. Preliminary plans have been drawn up for an L-shaped, two-storey building which will include a chapel and a nurses' residence on the grounds. The hospital, which will provide a total of 72 rooms, will be built for the Sisters of Saint Martha. Physical therapy, a sulphur pool, and therapeutic baths will be among the facilities provided.

CALGARY. An eight-storey nurses' residence which will cost over a million dollars is to be built at Holy Cross Hospital this year. The new residence will provide accommodation for 256 students, nurses, and course directors. It will also include laboratory, class, and demonstration facilities, visiting rooms, a chapel, library, auditorium and offices. Architects for the structure are Green, Blankstein, Russell and Associates of Winnipeg.

British Columbia

CAMPBELL RIVER. Tenders were called in January for construction of the new Campbell River and District General Hospital, which is expected to cost about one million dollars. The 56-bed hospital is to be built on the double corridor plan, and has been designed for enlargement when additional accommodation becomes necessary.

* * * *

MISSION CITY. Plans for an emergency wing to Mission Memorial Hospital have been approved in principle by provincial authorities. Although the hospital is planning a new 50-bed, $800,000 building to replace the present structure, a temporary addition is needed to alleviate overcrowded conditions. The wing will cost approximately $12,000, and will accommodate eight patients.

* * * *

PRINCE GEORGE. Although Prince George and District Hospital has a new $2,500,000 hospital building in the planning stage, a temporary addition to the existing building has been decided upon. The extension is needed to alleviate overcrowded conditions at the hospital until the new building becomes a reality. It will cost some $10,000 and will consist of additions to both ends of the maternity and nursery wing, increasing the hospital's capacity by four beds and four bassinets.

* * * *

VANCOUVER. The March of Dimes campaign which was staged recently for the Children's Hospital here went well over its $100,000 objective, breaking the past year's record in an all-out attempt to raise funds for the 83-bed hospital. Among the many individual group-sponsored campaigns, one of the most colourful was the Chinatown Lion's parade which netted more than $800 for the hospital.

VICTORIA. Tenders have been called for construction of two chapels at Victoria Veterans' Hospital, it was announced recently. Cost of the project is estimated at $45,000. One chapel will be for those of the Roman Catholic faith, while the other will be for Protestants.

Research Grants Announced

Eleven research grants totaling $401,960 for studies to aid in the improvement of hospital services have been announced by the United States Department of Health, Education, and Welfare. Among the recipients of these grants is the Association of University Programs in Hospital Administration, which will receive $75,000 for development of a program for research in the hospital and related fields. The American Hospital Association receives $71,487 for a study of the operation of hospital planning and license laws, while the Catholic Hospital Association of the United States and Canada receives a total of $10,100 for a two-point program. This will consist of a project to establish the tools, techniques, and training aids for a hospital supervisory development training program, and the development of a safety check list for hospital supplies and equipment.

For Hospital Housekeepers

The eighth annual Short Course for Hospital Housekeepers will be held this year at the Kellogg Centre for Continuing Education, Michigan State University, East Lansing, Mich., from April 2 to May 24. Sponsored jointly by Michigan State University and the American Hospital Association, the eight-week course is the only one of its kind in the country. The major purpose of the course is to enable the hospital to operate its housekeeping department more economically and efficiently by training its executive housekeeper in personnel methods and the latest technical advances.

The Brantford Experiment

A remarkable decrease in the incidence of tooth decay among the native children of Brantford, Ont., is revealed in the 1955 report on the dental effects of water fluoridation issued by the Department of National Health and Welfare. Two other Ontario cities —Stratford and Sarnia — served as controls in the study. The report revealed that children born in Brantford since fluoridation began in June, 1945, now have teeth which are as resistant to decay as those of corresponding age groups in Stratford, where the water has been naturally fluoridated for almost 40 years.

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4. Ice chamber and drain inaccessible to patient	Yes	No	No	No cooling	No
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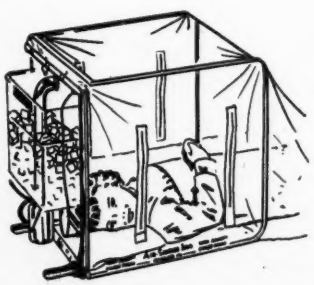
3. Filling of ice chamber	Outside	Inside	Inside	No cooling	Inside
4. Refilling of water supply	Outside	Inside	Inside	Inside	Outside
5. Mist apparatus integral part of tent	Yes	No	Yes	No	No
6. Storage compactness	Yes	No	No	No	No



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—For 1956—

Canadian Hospital Directory

The 1956 edition of the *Canadian Hospital Directory*, published by the Canadian Hospital Association, is now being prepared and will be ready for distribution within a few weeks. As part of the association's service to the field, complimentary copies will be sent to all Canadian public hospitals and to all supply houses whose advertisements appear in the directory. Additional copies will be available at $2.50 each or $2.00 each in lots of five or more. Orders may be addressed to the secretarial offices of the association at 280 Bloor Street West, Toronto 5, Ont.

Information on Institutions

The directory has been completely revised on the basis of 1955 statistics and general data. All Canadian hospitals and other institutions providing medical and/or nursing care (excluding certain military units) are listed by provinces in geographic-alphabetic sequence. In addition to the location and name of the institution the following information is given: postal address; telephone; ownership; type of operation or license; the number of beds set up for use, by type of service and in total; statistics on admissions, births, and operating budget; the number of personnel employed; and the names and titles of chief administrative and departmental personnel.

An over-all aspect of this information is given in tables which indicate the total number of beds set up for use and the type of care provided in such beds. These are divided into main classifications such as public general, public special, private, and federal. Subdivisions indicate the type of ownership under the headings, lay, religious, municipal, and provincial.

Educational Programs

An outline of the educational programs available to hospital personnel in this country is another important feature of the *Canadian Hospital Directory*. The programs listed include those for: administrators, dietitians, laboratory technicians, medical interns, nursing personnel, pharmacists, physical and occupational therapists, radiological technicians, medical record librarians, and social workers.

Hospital and Allied Organizations

Hospital associations and many other allied organizations in the health field are listed with the mailing addresses, names of officers, official publications, and dates and locations of annual meetings. This list includes departments of the federal and provincial governments which are of interest to hospital people.

Hospital Accreditation

This year a new section is provided in the directory on accreditation of hospitals. Included is background material, bibliography, information on the Joint Commission on Accreditation of Hospitals, the Canadian Commission on Hospital Accreditation, and other general data which will be useful to trustees and administrators.

Buyers' Guide

An important section of the directory is the Buyers' Guide which lists the products and services of the leading firms serving the hospital field. ●

University Medical Centre

(Concluded from page 37)

day when he decided to throw in his lot with us.

What of the other fears? Scarcity of clinical material has often been thrown up to us but that would appear to be among the least of our worries. The wealth of material seen daily in our sanatoria and cancer clinics gave ample promise of an adequate number of cases in other fields for teaching purposes. All that was needed was an institution like the hospital we are opening today to make those cases available to our students. Although this promise has still to be proved, there is no reason to fear that we will be handicapped in this respect.

There remains the matter of cost. The establishment of a medical school is a formidable undertaking. This school owes its existence directly to the announcement of a scheme of compulsory health insurance. This announcement spotlighted the fact that existing facilities were insufficient to provide first class medical care for everyone. That fact remains even though the plan which gave it prominence has not yet been carried out. We are convinced that the establishment of this school, shown to be necessary in 1942, will do more than anything else to improve the standard of medical care in this province. It is impossible to draw an even balance between medical care and costs — to evaluate improvement in health in terms of dollars and cents.

The government appreciated this and approved the plans of the university senate to go ahead with the establishment of a medical school. To make it possible the university hospital was built and generously equipped. It was done simply and solely because the needs of the people demanded it. The primary object of this undertaking is not to teach medical students, nor to do medical research, nor even, in the final analysis, to treat the sick, important though all these are and essential though they may be to the main objective. This objective is the welfare of the people of this province and to that, and to that alone, is this undertaking dedicated. We believe that health is essential to this welfare and that this hospital and medical school can contribute to this end by providing a place where the sick can be healed, where students can be properly trained in the arts of healing, and where medical knowledge can be advanced.

And so we come back to the basic principle on which this university was built, an institution devoted to the welfare of the people whose vision and sacrifice brought this university and this hospital into being.

Time to Think

Chronic hurriers usually believe that unless they are actively engaged in pushing, striving, thinking, and working every moment, they are wasting time. Most of us stay in such a state of hurry and tension that we never give our subconscious a chance to work for us. We go through life trying to solve all our problems and get all the answers with our puny little conscious intellect, when there is a giant in the background waiting to serve us. And here again, the way to make your subconscious work for you is to relax your muscles, and to learn to keep them relaxed except when they are needed for a specific task.

Create a mental "slow" sign in your mind and, every time you feel a sense of hurry, deliberately slow down. Slow down not only your physical movements but slow down on the desire to go faster than your most efficient pace. Be willing to take it slower. In other words, don't let your foot ride so heavily on your mental accelerator. Ultimately you'll go faster and get more done by increasing your natural tempo — not by forcing time. — *"The Canadian Nurse"*

A Measure of Success Achieved—

CHAM Moves into Second Edition

BEYOND any shadow of doubt, the quality of record keeping in Canadian hospitals generally is vastly improved over that which prevailed some five years ago. Statements such as the foregoing, made by senior hospital accountants, hospital association representatives, and governmental personnel alike, are heartening words indeed to members of the Canadian Hospital Association's committee on accounting and statistics. That this opinion is justified is supported by a recent statement from an official of the Bureau of Statistics to the effect that there has been a steady improvement in the quality of statistical returns. This applies to both the general and financial reporting schedules, which are submitted annually by hospitals to their respective provincial departments of health and to the Dominion Bureau of Statistics.

Assessment of the exact extent of the general improvement and of the swing towards greater uniformity in hospital accounting and statistical information is, of course, difficult. It is interesting, however, to try to analyze the causes and the effects of the improvement. The most obvious factor contributing to the accelerated progress of recent years is the widespread acceptance and use of the *Canadian Hospital Accounting Manual* since it was compiled and distributed four years ago. Of equal importance has been a revitalized interest in facts concerning hospital operation, expressed in both statistical and financial terms, on the part of hospital trustees and administrators, departments of government, other so-called "third-party" agencies, and the general public. Educational institute programs, many of which were well established long before the introduction of the accounting manual, conventions, and other meetings of hospital personnel, have directed attention more deliberately and intensively towards hospital accounting. In addition, many specialized educational programs, conducted in various parts of Canada, have been aimed directly at improvement in hospital accounting, statistics, and financial management. The interest and enthusiasm of provincial departments of health, so evident at the Dominion-Provincial Conferences on Hospital Statistics (in themselves most noteworthy events), has been sustained through the intervening period, thus encouraging and supporting the activities of hospital people.

Each of these, and other factors which come to light in the course of analytical review of the developments over the past few years, can be credited with contributing its share to the progress which is evident. Nevertheless, the undercurrent which can be detected in all of them, the element which is always present, seems to be the accounting manual itself. It has been the dependable common ingredient in the mixture of circumstances and events following the Dominion-Provincial Conferences. It has been the catalyst making the mixture smooth and palatable so that the successive efforts of many have complemented each other, resulting in steady progress.

Now "CHAM", as the accounting manual has come to be known colloquially and affectionately by its users, is being revised. When the revision process is completed, a second edition will be issued. Briefly, the objectives of the revision are to keep pace with developments in the hospital field and, in the light of four years of practical experience, to remove weaknesses which have become evident and to improve the usefulness of the volume as a quide and reference book for hospital accounting personnel.

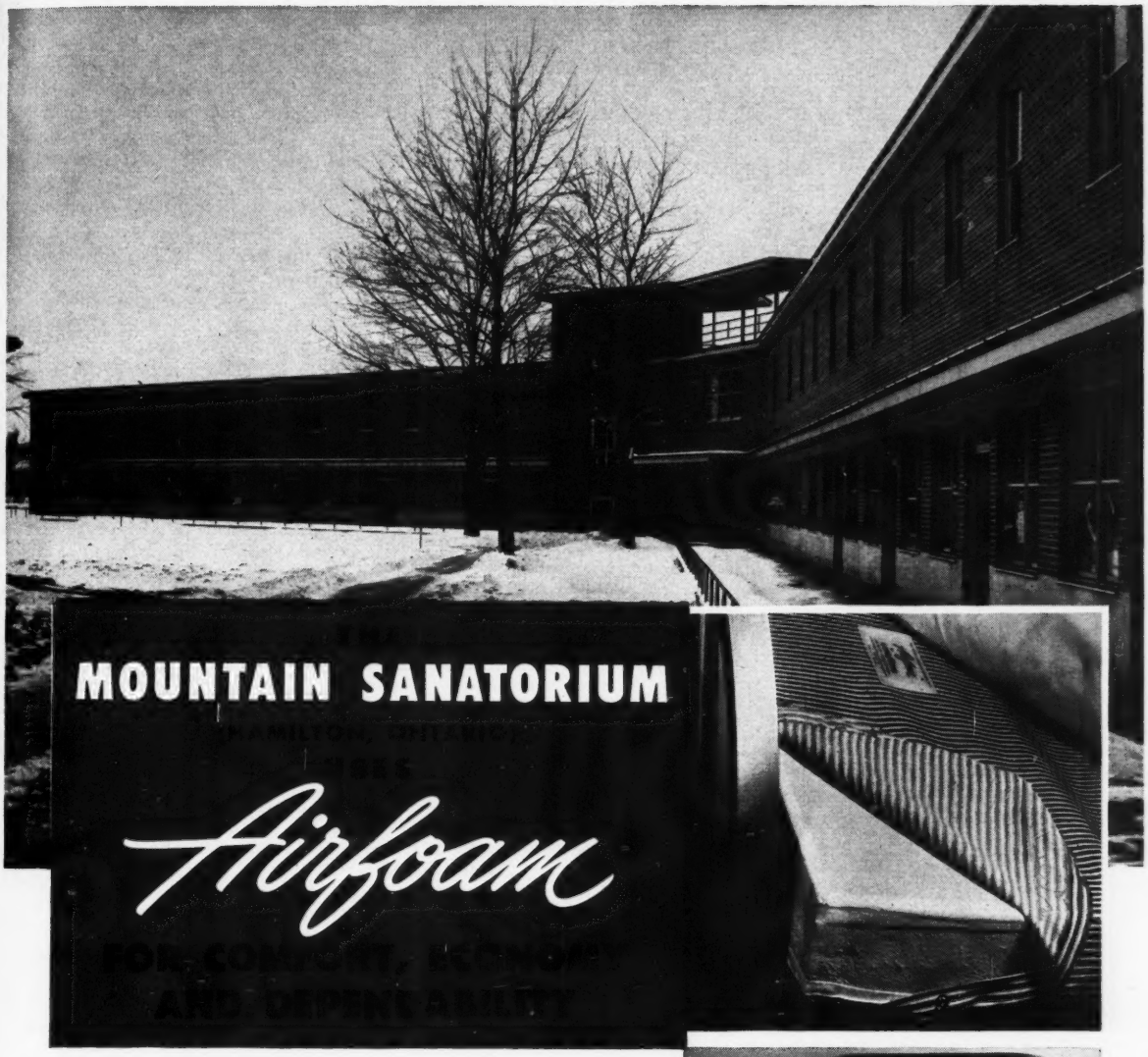
Essentially the same procedure is being followed in the revision program as was used in the original compilation of CHAM. As draft material is developed, it is circulated to members of the committee on accounting and statistics, hospital associations and conferences, departments of government, and members of the public accounting profession. It is also sent to any others who show interest and who are prepared to review proposals, offer criticisms and make suggestions. Editing and other work relating to the revision program is being carried out at the offices of the Canadian Hospital Association, under whose auspices the manual is published.

Suggestions from interested persons or groups are invited. In fact, everyone who has occasion to make use of CHAM is urged to submit any thoughts or ideas, which he or she has, to the general pool of knowledge and experience so that all such thoughts and ideas may be taken into consideration as the revision program progresses. Persons making suggestions who normally use the English edition of CHAM, and who speak the English language, may communicate directly with the Association's offices at 280 Bloor Street West, Toronto 5. Those who normally use the French edition of CHAM *(Manuel de Comptabilité des Hôpitaux du Canada)*, and who speak the French language, may direct their suggestions to the chairman of the French-language subcommittee, Gaspard Massue, 6055 St-Denis Street, Montreal 10.

It is hoped by the editors that this "call to arms" may prove to be more productive of response from the hospital field than has been any other single appeal, made in this way, for suggestions and ideas. It is essential that *you*, the reader, who have applied and used the *Canadian Hospital Accounting Manual*, take note. Only through *your* wholehearted co-operation can the vast pool of experience of the past four years be made fully available and useable. Only in this way can you be assured that changes which you would like to see made can be given proper consideration. Only in this way can best results be obtained in the second edition of CHAM.—*M.W.R.*

Atomic Hospital

Upton, N.Y., is to be the site of a new atomic hospital and medical research centre, according to an announcement issued recently by the Atomic Energy Commission. It will have an atomic reactor, designed solely for medical use, which will produce many kinds of radioactive atoms for use against cancer and other diseases and in research into causes and treatment of various diseases. It will also produce x-rays and neutrons—atomic particles released by the splitting of atoms—for direct use on human patients. Completion of the structure is expected within two years, with the cost estimated at $6,000,000.



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THE WORLD'S FINEST CUSHIONING

Social Sciences

(Concluded from page 40)

The Social Psychology of Industry, published in 1954 by Penguin Books. Dr. Brown's discussion of morale and the impetus that causes men to want to work is almost as relevant for the hospital as the industrial plant. If the analysis made by social scientists who have studied institutional organization be applied to large complex hospitals, the cause for the frequent failure to supply the basic needs of employees becomes apparent.

That cause is the traditional and inflexible nature of the formal social structure of the hospital. Let us think of it for a moment as it would appear on an organizational chart. The chart would show parallel horizontal lines representing authority and status. At the top of the structure would be the board of trustees; at the bottom, so far as direct patient care is concerned, would be the aide or orderly. The chart also would show parallel vertical lines representing functions or services, such as the medical, social work, nursing or physiotherapy service. At the top of each of these vertical lines would be the persons responsible for planning and administering the service, at the bottom, those responsible for carrying out orders at the point of immediate contact with patients. Under this organizational structure everyone would function within a relatively well-defined area; and for those numerically very important groups at the bottom of the hierarchy, within closely circumscribed areas.

This limitation to functional movement either upward or outward is accentuated, moreover, by the fact that communication moves primarily only in one direction — from persons with more authority and higher status to those with less — and the communication is phrased largely as orders, pronouncements, and announcements. Few plans or even suggestions and pertinent information flow in the other direction, while reasonable requests for supplies or repairs often move so slowly and with such distortion along extended lines of communication that patients and floor staffs conclude that "the hospital" is not interested.

The effect of the formal organization of the large hospital, thus analyzed, is obviously the opposite to what would be required were floor staffs to be given recognition, a feeling of importance, and a sense of contributing to a group therapeutic effort. The problem becomes, therefore, one of striving to discover how these two apparently irreconcilable sets of factors can be more nearly harmonized. Some hospital administrations have rather naively assumed that if increased praise and decreased blame of ward personnel would improve morale and efficiency, little more was required than a suggestion to those in positions of authority that they alter their behaviour when on the wards. Unfortunately, behaviour patterns are not likely to be changed, or remain changed, if the social organization continues inflexible and no attempt is made to re-evaluate and restructure the roles ascribed to the lower echelons of personnel.

Recently a few hospitals have experimented with altering relationships among staff by creating *situations* that foster less reliance upon authority and status and more upon co-ordinated group effort. The results have been promising enough to encourage these hospitals to attempt to discover how such situations can be expanded in number and scope and made to contribute the maximum possible to breaking down harmful barriers. Time permits illustrative reference to only one type of situation. Hence the weekly or semi-weekly wardstaff conference has been selected because most persons have some acquaintance with it and it has proved potentially useful in improving patient care. Although it has been employed in many places for discussion of management of patients or altering ward conditions, it is capable of greater effectiveness and of serving more ends simultaneously than has generally been supposed. Success has frequently been limited because the resident physician did not attend, monopolized the discussion, or kept reverting to considerations of diagnosis and treatment; because only the morning shift was represented or aides and orderlies were not included. If a total staff be present and a permissive atmosphere cultivated, such meetings are capable of encouraging movement on several fronts concurrently. The discussion of patient care and ward conditions is extremely valuable in itself. But an opportunity has also been provided whereby anxieties can be expressed and support offered; frustrations and annoyances aired and often resolved; personnel who have never before uttered an opinion helped to participate and thereby to develop greater occupational competence; and the entire staff gradually woven into a closely co-ordinated team of workers.

In a project on improvement of patient care in large psychiatric hospitals that Russell Sage Foundation lately sponsored, results of which will shortly be published*, the ward psychiatrists for the selected experimental areas concluded that they could not raise the level of care appreciably unless the ward staffs were individually and collectively taken into full partnership. The ward-staff meeting was one of the chief instruments employed for creating and maintaining that partnership. I wish I could report in detail on the changes that were achieved in a few months. It is only possible to note that changes were of an order that made many visitors hesitant to believe that these were the same wards and the same staff they had seen prior to the beginning of the project. Motivation came to run so high that the personnel vied with each other to see who could think of more or better ways to improve conditions; one physician in particular was subjected to great pressure to initiate further undertakings. Almost all staff reported to the social scientist who acted as observer that they were more interested in and satisfied with their work than they had ever been before. One supervisory nurse stated that in his fourteen years of psychiatric nursing he had heard much talk of the team, but this was the first time he had ever seen it in practice. Best of all, improvement even of long-time chronic patients was pronounced; and both patients and their families showed far more satisfaction with the hospital than formerly.

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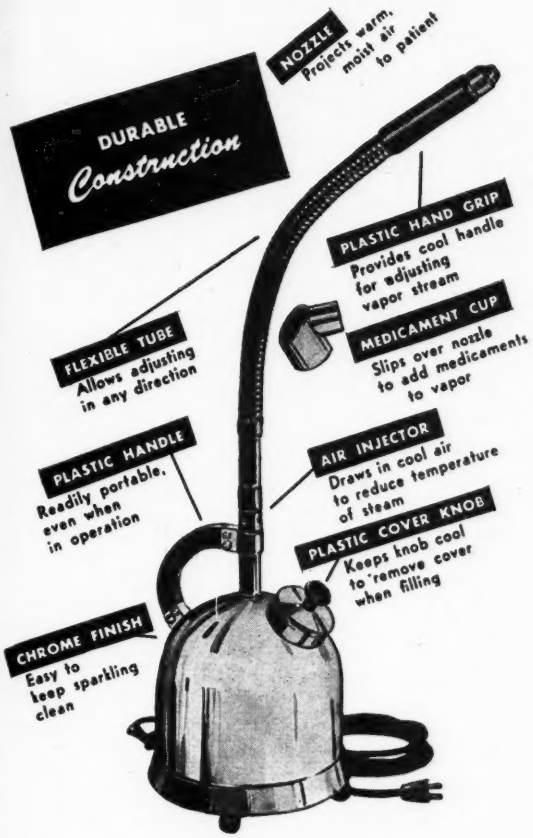
*"*From Custodial to Therapeutic Patient Care in Mental Hospitals", published, November, 1955.* *(See page 56, this issue.)*

THE MYRICK INHALATOR



Note: Action of air injector can be demonstrated as follows: Start Inhalator in operation and when vapor is being projected from nozzle, wrap a handkerchief or other material over the four holes in tube just above handle. This cuts off air supply and steam coming out of nozzle will not be projected. Remove handkerchief and notice how vapor is again projected.

Entire contents of Inhalator must come to a boil. Warm up period can be reduced by filling with hot water.

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Choosing a Successor

Wm. M. Gray,
Member, Board of Trustees,
Public General Hospital,
Chatham, Ont.

SOMETIMES, after much weary effort and the seeming disinterest of so many as against so few, one might be pardoned if he pondered on the folk who perform the many acts above and beyond their own needs of the day. That is why I say to you, "You don't make trustees . . . you catch them".

Among the delusions offered us by fuzzy-minded people is that imaginary creature, the common man. It is dinned into us that this is the century of the common man. The uncommon man is to be whittled down to size. The humour of it is that, when we get sick, we want an uncommon doctor. When we go to war, we want an uncommon general or admiral. When we choose a trustee, we want uncommon ability.

Our imperative need on a hospital board is the initiative of the uncommon man or woman; a member who cannot be intimidated, who is not concerned with applause meters, nor who sells the "morrow" for the cheers of the day.

On this continent there are 70,000 to 80,000 men and women serving on governing boards of some 7,000 or more hospitals. Trustees are esteemed and respected citizens of the community. They are imbued with the spirit of service to their fellow man in his illness, accident, or distress. They are guardians of patient care and welfare, evolving a bulwark of health for the community.

Surprisingly, most of them are efficient at their task, since painstaking thought has gone into their selection. They are outstanding in their community. "As with one peak in every mountain range, by some intrinsic splendour, stands apart."

You can count the seeds in an apple but you cannot count the apples in a seed. If in choosing the worthy in a successor and if a strong nominating committee is appointed, at least you can count the seeds in the apple. For such a committee, you can do no better than to have it consist, in the majority, of past presidents, the administrator, with the ladies suitably represented.

And now being off to a start . . . beware of those motivated by "pride of knowledge"; somehow they always manage to complicate simplicity. If you choose, in the vernacular, a loud mouth, sooner or later you'll be tempted to perform a "yappendectomy". Similarily, skip the one track mind, traffic may be very light on it; rather search for the flexible mind. Charles Kettering put it this way: "Show me the man possessed of the 'Tomorrow mind', not the 'Yesterday mind' ".

Let diversification stand high in your guidance procedure that you may bring to the board the composite knowledge and experience of your community. Have as ingredients for your melting pot (or should I say pressure cooker), the cumulative attitude of the merchant, the manufacturer, the contractor, the banker, the lawyer, the clergy, public utilities and civic officials, the medical and nursing professions, and the women's aids.

So now the nominating committee, having lowered its sights on a likely individual, should carefully assess "him" or "her" in the light of the ten basic requirements to follow, purloined in part from an institute for trustees, held in Hawaii some years back.

1. The trustee should have community approval. Let him be well past his proving ground by days spent in other community services, where he has established respect.

2. . . . have sufficient time. He who comes late or grumbles all during the meeting or leaves early consistently will be happier in other endeavours.

3. . . . have a consuming interest. This means more than the casual thinking about hospital interest between meetings, as well as at meetings.

4. . . . be able to differentiate between "policy" and "execution". If he cannot he probably would be much happier as a hospital administrator, than as a trustee.

5. . . . have courage to make unpleasant decisions when necessary. This does not mean making unpleasant decisions unpleasantly but firmly, freely, and with conviction when necessary.

6. . . . never allow popularity or personal advantage or commercial gain to take precedence over prudence.

7. . . . be a participant, not an attendant at board meetings, taking part in evolutionary action not revolutionary acts, lest all chairmen be not as gentlemanly as Will Shakespeare . . . you know many times he wrote, "Go To", but he never finished the sentence.

8. . . . should have acquired that spark of humanity in his heart, which allows him to evaluate his actions by the good accruing to others. Most of what a trustee does goes unacknowledged. We work for a goal that is far distant.

9. . . . be able to thrill to the medical miracles in his house of healing even more than he thrills over the beautiful new lobby. A city, as a city, does little to correlate its human particles into a pattern of responsible communal living. Shrivelled contacts through the increase of technology have impoverished the neighbourly relations between the members of a community.

10. . . . be a general practitioner of his trusteeship, not a trustee specialist. Special skills are valuable but they can be purchased. Not every one can do great things but every one can do "small things" in a "great way".

For the "don'ts" then:

(a) The wrong way to pick your board members . . . "Is to pieces".

(b) Again, in the precinct of a hospital, there is no worse patient to nurse than a "grudge".

(c) And lastly, never penalize "attitude in action".

This humour, in verse, carries a moral . . .

At meetings of boards, by an effort of will
I should always contrive to keep perfectly still
For it takes but a word of annoyance or pity
And Wham! There I am, on another committee.

From an address presented at the trustees section of Ontario Hospital Association Convention, Toronto, October, 1955.

"New Hearts for Old"

A new film, "New Hearts for Old", was recently produced by the National Film Board as the second in their television series "Perspective". The film follows a victim of a heart attack from the time of his first seizure until he undergoes surgery. It was shot at the Institute of Cardiology in Montreal, a division of Hôpital Maisonneuve devoted to the study and treatment of heart disorders, and was televised last December. The first film in the above series, "Raw Material", tells the story of the work of the John Howard Society in assisting former prison immates.

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MINNEAPOLIS **Honeywell**

Hospital Room Temperature Controls

Hospital Finance

(Concluded from page 46)

(3) Comparative statistics of work volume in all major departments are another essential review requirement.

Making a Survey

After you have analyzed and studied this information you are ready to commence the survey. By this time you may know where best to concentrate your attention — not that other areas should be overlooked. Remember, it is important to bring all department heads and employees into the picture. It is surprising how many excellent ideas they have for improving patient care and efficiency; ideas that they may have failed to present before, because of some break in the lines of communication.

Some of the hospitals requesting surveys do not have up-to-date financial and statistical records. In such a situation it must be very difficult for the administrator and the board to know just where they stand. Lack of administrative controls seems to go hand in hand with the failure to have proper budgetary controls.

Department-head meetings are important to ensure co-operation in the solving of problems. The lack of communication between hospital departments and their failure to work together, as a team, can lower the level of patient care. Hospital departments are not insular compartments. Misunderstandings and friction between departments should be overcome through the development and appreciation of a common goal and purpose. Employees work for the patients and the hospital — not for a particular department.

The administrative staff should not be tied down to a desk doing routine work that might be carried out by a clerk. Co-ordination of departmental activities and their integration with other deparments has become even more important with the shortening of the work week and increase in the number of staff required to do a 168-hour job each week.

In some hospital departments all staff work Monday to Friday and one employee is frequently called back on Saturday. Would it not be possible to stagger the days of employment to ensure coverage on Saturday and avoid over-time pay?

Extra money spent on salaries in the laundry and other service departments due to inadequate equipment means that much less for patient care. It is essential that the laundry equipment be more than adequate to handle the normal load. The week-end accumulation should be disposed of early in the week.

In one hospital where bed capacity was increased without adding to the laundry equipment, they have this situation:

(1) Minimum washer capacity.

(2) The extractor is too small. Requires three extractor loads for each wash load—result: insufficient time for extraction and slow-down at the ironer.

(3) Tumbler capacity too small.

(4) The ironer has only one speed—too slow. Many items have to be put through the ironer two or three times.

(5) The space is inadequate and not properly ventilated.

The staff in this hospital laundry work hard but cannot overcome the bottlenecks. It is considered that with adequate equipment this hospital could save between $5,000 to $6,000 a year in the operation of their laundry.

Staff time can be saved by adequate equipment for the preparation of vegetables and cooking. A dishwasher that does not have a booster tank capable of maintaining 180 degrees rinse water is not satisfactory from a sanitary point of view and can increase labour costs since dishes will not dry properly unless assisted manually by a dish towel.

It would seem that some hospitals consider the only way to meet increased expenditure is through an increased patient rate. An increase in revenue of $1,000 is just about as good as a budget increase for the same amount. In some cases hospitals have offset increased expenditure by increasing revenue.

Are your room differential rates adequate? What percentage of these charges are collected in advance and can collections be improved? Remember 40 per cent of the room differential collections are retained by the hospital. Some hospitals have quite difficult problems in connection with room differential collections; but others, through a variety of approaches, have overcome much of the difficulty.

Are your medical staff aware that a reduction in your out-patient revenue may necessitate a reduction in the services you are able to provide and that an increase in out-patient revenue would help the hospital?

Many hospitals are selling meals to staff and others at a loss. If your food cost per meal is 30 cents, you can be certain that when you include the cost of preparation, serving and dishwashing, the meal will cost the hospital 50 to 70 cents, if not more. Some hospitals consider that the cost of a meal is raw food cost. If they follow this policy every meal they serve, to other than in-patients, represents a loss of hospital funds.

Quite a number of hospitals are now charging employees and others for coffee and refreshments — others make no charge. Some hospitals charge five cents per cup, others have a set monthly charge which is deducted from the payroll. It is estimated that the average hospital of 100 beds, providing coffee to staff, morning and afternoon, could increase its annual revenue by $2,000 to $3,000 with a charge of five cents per cup.

Other Areas

Many other areas of revenue and expenditure should be reviewed, depending on the situation in the hospital. If drugs and medical and surgical supplies are a problem, find out which constitute the major expense items. If there is duplication of drugs with simliar medicinal properties, ask your medical staff to assist through the formation of a pharmaceutical committee.

For food, check on purchasing, receiving and weighing storage control, portion control, method of serving meals, and waste. I might mention that one of the larger hospitals reduced its expenditure on milk and cream by over $4,000 this year through competitive purchasing.

For fuel and other supplies try calling for quotations not just for a month's supply but for six months or a year, to see if you can arouse some competition for your order. Check on any areas of your building where steam and heat are not required.

Conclusion

In conclusion I would like to refer to a statement I made at your convention in 1953. I stated, "The financial relationship between British Columbia hospitals and the source of the major portion of their funds, the Government, is unique. In most government activities, decisions that will increase expenditure or taxes are made by the authorities responsible for imposing the taxes." The expenditure of funds on hospital care, prior to the Hospital Insurance Service, was determined by local authorities or hospital boards and the costs, at least to a considerable extent, were paid by local residents. The taking away of local responsibility for the collection of hospital operating funds and placing the collection in the hands of a central government, which is responsible to the taxpayers of the Province as a whole, is bound to create problems. I think we should keep this anomalous situation in mind. It may be some time before a permanent solution, satisfactory to all concerned, is found.

You can never get ahead of anyone as long as you are trying to get even with him.

Rehabilitation Study Session

Students at the University of Toronto's post-graduate course in hospital administration at the School of Hygiene recently visited the Workmen's Compensation Board in Toronto for a study session on rehabilitation. Left to right: W. B. Stefaniuk, H. R. McGann, M. Katz, G. D. Barnett, G. A. Miller, L. Brousseau (Records' Division, Workmen's Compensation Board), A. B. McCartney (Medical Aid Officer, W.C.B.), G. Fortune (Assistant to Chief Claims Officer, W.C.B.), Dr. B. H. G. Curry (Chief Medical Officer, W.C.B.), W. B. Beatty, Dr. V. H. Radoux, Miss E. M. Stuart (Associate Professor, Dept. of Hospital Administration, University of Toronto), and C. R. Horton.

Medical and Hospital Care

(Continued from page 42)

which new community programs of prevention can be based.

Quality of Hospital Service

The second path of progress I see is towards strengthening the quality of services in hospitals in Saskatchewan. In a sense, the rapid strides in hospital construction and service of the past decade have been mainly quantitative. They have brought within reach of rural people — both geographic and financial reach — a supply of beds more adequate to their needs than is probably to be found in any comparable rural region in the world. But, with such rapid growth, it was inevitable that the quality of hospital service would not always meet the highest standards. The coming years must concentrate on improvements in the quality of hospital services. In my opinion, this requires above all else active promotion of teamwork among groups of hospitals in geographic regions.

A master plan for Saskatchewan hospitals was formulated in the 1951 Health Survey Report, based on the concept of regionalization: hospital networks in which there would be a flow of technical services from the centre to the periphery and referral of patients with complex disease problems from the periphery towards the centre. A beginning has been made in testing this idea with the appointment of a Regional Hospital Co-ordinator in the Swift Current Health Region; and one would like to see the pattern explored at an early date in the region surrounding the University Hospital. I know of no better hope for assuring rural people the benefits of modern medicine. With improvements, moreover, in roads and methods of transportation, there will be much less need in the future for many of today's small, improvised hospitals —community centres that have nobly served a purpose but can no longer hope to provide scientific service at a reasonable cost.

To construct hospitals in tune with modern medicine is expensive, and many of the existing structures require replacement or extensive modification. The financial resources of all the people in the province are needed; yet a substantial minority do not now contribute to these costs. The principle of spreading costs within union hospital districts, developed over the past forty years, can surely be extended now to encompass all the people, since all use the hospitals.

The University Hospital obviously has a tremendous role to play in elevating the quality of service in the province's 160 general hospitals, not only by example but also by specific training programs. In service training for nurses and dietitians, pharmacists, technicians, and others, could be offered, complementing the advisory services of the Department of Public Health. Leadership should also come in the more difficult sphere of medical policy, especially as it affects hospital admissions and discharges. Objective criteria for hospital admission and continued hospital care can be applied by physicians, if they set out to do it systematically. The University Hospital can also demonstrate the operation of the "medical audit", which could help to boost the quality of performance in every hospital in the province.

Enlightened health leaders everywhere see the hospital as a centre with functions going far beyond the bed care of the seriously ill. They must be centres also for research, for training, for prevention, and for extension of scientific techniques to the ambulatory patient. The University Hospital will doubtless demonstrate all these functions and inspire other hospitals to do likewise. Much remains to be done in strengthening hospital outpatient services for diagnostic and therapeutic procedures which cannot be properly undertaken in the average physician's office. Perhaps these would be the next logical extension of public benefits under the Hospital Services Plan.

Medical Services

Just as the University Hospital can catalyze a whole chain of improve-

(Continued on page 80)

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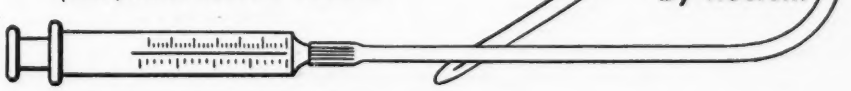

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ments in hospital service, the College of Medicine has a central place on the third path to the future: strengthening the quality of medical services throughout the province. Fundamentally, this promising new school will train doctors, and more doctors are needed in Saskatchewan. One may hope that students here today — and most of their successors — will engage in practice in this province.

Equally important, the university will soon be a centre for post-graduate medical education. All physicians must educate themselves throughout life, but for the isolated country doctor the need is urgent. With the aid of the College of Physicians and Surgeons and the Department of Public Health, the College of Medicine can carry out a continuous program of educational conferences at regional centres all over the province. Moreover, the availability of this topflight centre for referral of difficult diagnostic or therapeutic problems — with reports going back to the family physician — will sharpen medical acumen everywhere.

Beyond this, perhaps more direct steps should be taken to reduce the isolation of the rural doctor. Group medical practice is well known on the prairies, yet scores of villages have their lone doctor; and in Saskatchewan an alarming number of hospitals have a medical staff consisting of a single practitioner. It is a difficult problem, for surely every area with 1,000 to 2,000 persons requires a general practitioner within easy reach. Perhaps a solution can be found in encouraging medical groups in the town to take in country doctors as full members, even though the latter would serve primarily at outlying rural points. Construction of health centres to house such groups might foster the idea. Then, the rural member of the group would feel free to refer to his associates complex medical problems confronting him.

The age-old problem of medical costs has still not been solved completely in Saskatchewan. Between the various governmental and voluntary programs of medical care, perhaps 40 per cent of the population enjoys a fair measure of financial protection. Extension of voluntary plans may enlarge this proportion somewhat; but world-wide experience convinces one that no reliance can be placed on voluntary enrolment to achieve anything approaching full population coverage. I can only remind you of the recommendation of the 1951 Health Survey Report that prepaid medical services be extended to everyone in the province, financed by federal and provincial tax sources. In the absence of federal assistance, the pattern of financing which has proved effective in the Swift Current Region might well be extended to other regions.

Without proper economic support, many efforts to improve the quality of medical service in Saskatchewan, or elsewhere, will be sterile. The patient must first have access to the doctor, both the general physician and the specialist, without economic deterrents. Then, the first-class medicine which this medical college will teach and demonstrate can be applied.

Long-term Care

Finally, there is a fourth path to the future that I see, a path made necessary by past accomplishments. Because of the achievements of public health and clinical medicine, people are living who formerly died, and they are living with a great accumulation of disabilities. This rising volume of long-term illness and disability, especially among the elderly, presents a problem of wholly new proportions that demands special organized measures in Saskatchewan and elsewhere.

The number of mentally disabled has been rising insidiously for many

years. A vicious circle is created, for the more crowded the mental hospitals become, the less effectively can they treat the patients, the fewer are the cases discharged, and the overcrowding increases further. The additional mental beds needed to break this circle should in my opinion be provided in a number of moderate-sized facilities close to the people, preferably in each of the province's regional cities and usually in conjunction with a general hospital. This would also distribute psychiatrists more evenly over the province and permit further extension of community mental health clinics.

The aging of the population has confronted Saskatchewan with an enormous housing problem, often solved extravagantly by prolonged hospitalization of elderly persons whose medical needs are slight. Nursing homes for the aged are, of course, operated by many local bodies, and the provincial Department of Social Welfare has established others. The whole complexity of problems of the aged and chronically ill, however, deserves the most searching study. The needs for housing must be distinguished from those for health service, with the latter being tackled in conjunction with hospitals. Special chronic disease wings may well be attached to general hospitals, or nursing homes be built closer by, in easy reach of medical services. On the other hand, the housing of elderly persons not in need of medical care requires no special ties to hospitals.

In the larger centres, home care services for the chronically ill can be organized, as extension functions of the hospital. Medical social workers are needed to help organize such programs, not to mention the other services they could provide for hospital patients. In every hospital, the affirmative and optimistic viewpoint of modern geriatric medicine should replace the fatalism of the past.

For the seriously disabled among all age groups, the whole rehabilitation movement, which has had a robust beginning in Saskatchewan, requires strong support. Rehabilitation centres are needed to cope not only with cases of poliomyelitis and cerebral palsy, but also arthritis, post-traumatic problems, hemiplegia, and other prevalent disorders. In addition, departments of physical medicine are needed in all regional hospitals. The new program of allowances for the permanently and totally disabled makes all the more urgent a vigorous rehabilitation service in the years ahead.

In all these needed endeavours to cope with the mounting burden of physical and mental disabilities, both the College of Medicine and University Hospital must provide vigorous leadership.

These four paths to the future are, of course, intertwined. Others might visualize the next steps in Saskatchewan's health service along different lines or in other proportions. The tasks are many, but the goals are important. Knowing as I do the quality of the people of Saskatchewan, the devotion of their leaders, and the will of both to move ahead, one can look to the future with assurance.

Seldom has a university medical centre faced such opportunities for creative leadership as prevail here in Saskatchewan at this mid-point in the province's first century. Building on a heritage of health organization which is the envy of informed persons in other provinces and nations, the College of Medicine and the University Hospital can and must accept the weighty burden of leadership in speeding the unravelling of age-old problems of personal and community health. ●

Tomorrow's Doctor

(Continued from page 44)

Brown has indicated, in the sociological areas of medicine as well as in the biochemical. We must experiment not only in maintaining the hormone balances or the electrolyte equilibria of the blood but also in methods of carrying medical care to the people. Canada is doing that.

One of the things one must study is group practice. We have some group practice in the United States and there is some in Canada. There are all kinds of groups; some are private, some are run by local, state, or national governments, some are on prepaid comprehensive medical care plans. I think the last mentioned is best and something we should work for, whether run privately or by government. Some groups are still on fee-for-service; but fee-for-service, perhaps, on a fee-scale basis is better than the soak-the-rich, charge-what-the-traffic-will-bear system of the olden days. Great Britain is a much more homogeneous country than either Canada or the United States. It is made up mostly of English people, whereas Canada is made up of at least two main races and the United States is made up of many. Different kinds of solutions to these problems are required in different places. You must have plans for urban areas. New York City, I think, has done a wonderful thing in setting up the Health Insurance Plan of Greater New York, which now has half a million subscribers, most of whom are quite contented and so are most of the doctors. The younger doctors who have grown up in this setting like it very much, although the local medical societies all around greater New York have tried to put the plan out of business. It is growing; it is flourishing. It is an important sociological phenomenon and perhaps New York will catch up with Saskatchewan sometime. So you must have urban plans; you must also, I suppose, have suburban plans, and you must have rural plans.

Then there are labour and industrial health plans. I visualize sometime a health insurance plan of Greater Boston. Something like H.I.P. in New York, but going further in that it would be hooked in with the educational process. Some of the practice groups could be made up from the staffs of the teaching hospitals. Then the other local hospitals could be taken in. I would also tie in the health plans of the institutions of higher learning. In Saskatoon you have a great advantage in that everything is in one package and that is very important. You are all on one campus. In an old city like Boston, we have about five universities and they are widely scattered.

In medical teams there must be a proper balance. In place of the term "general practitioner" I prefer the term "generalist" to balance the word "specialist". In the group, whether it is in the teaching hospital or in the community hospital, there must be a proper balance. In the groups of H.I.P. of Greater New York there is such a balance. It has been carefully studied and planned. There are the necessary specialists and an adequate number of generalists. The patient belongs to the generalist and the generalist makes use of the specialist, as needed. He has the responsibility of tying all the specialized work into one package —the over-all care of the patient. He must see that the patient benefits from the plan which has been evolved through the combined work of the generalist and the specialist. I would say that the specialist has no greater dignity than the generalist. They all have their functions in the team; and

(Concluded on page 88)

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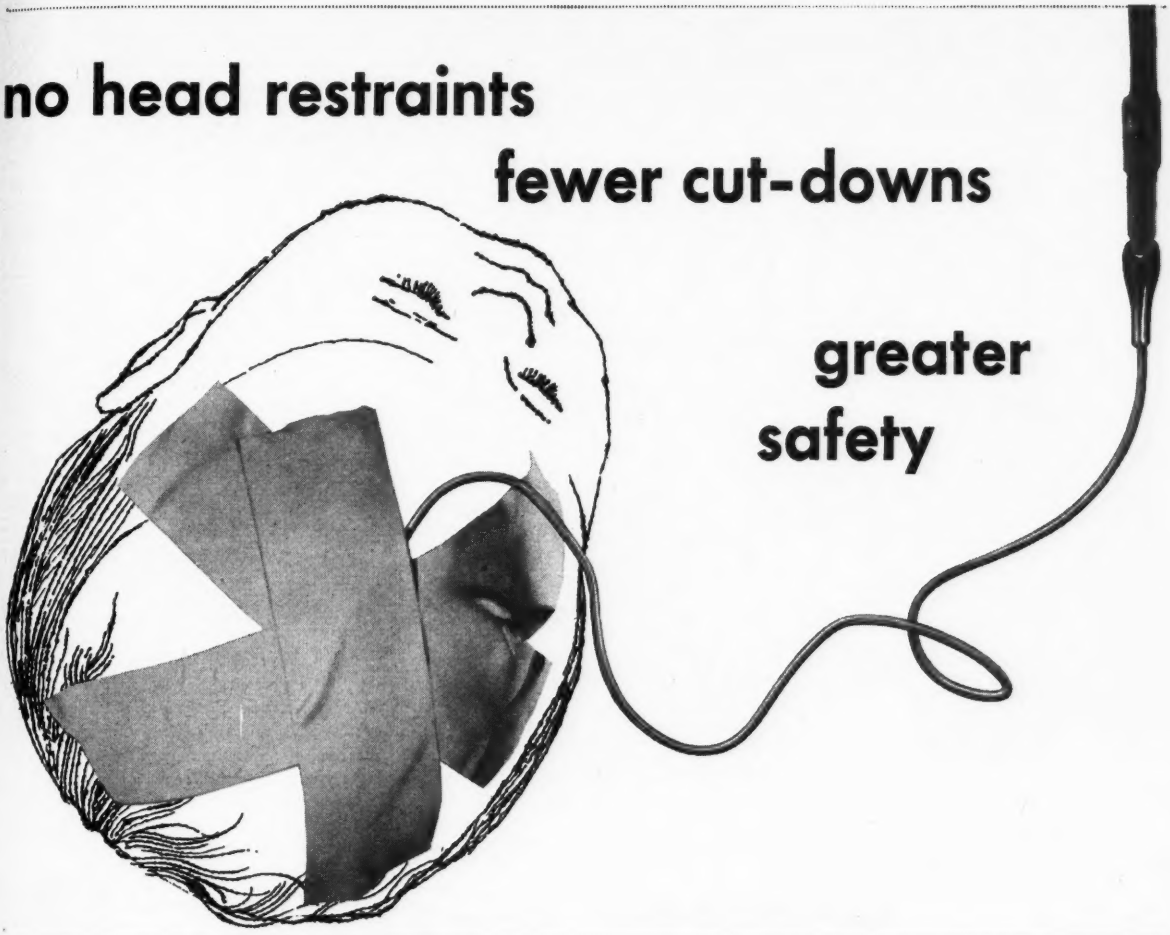

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Tomorrow's Doctor

(Concluded from page 84)

they must integrate and work together with understanding of their respective duties. We must prevent the isolation of the doctor of medicine, not so much geographic isolation as intellectual or even moral isolation.

In most of our colleges we have a certain group of students who have decided they want to go into medicine; they are called "premedics". Other students tend to avoid them. They talk to each other. They even have their own fraternities and sometimes universities actually set up courses especially for premedics. I deplore all of that. Then when they get to medical school, they are thoroughly isolated. They think, do, and dream about nothing but medicine. Then they become interns and later residents. What do they think about then —medicine! Finally, the student becomes a practitioner and goes to medical society meetings and gets still more out of touch with non-medical people and ideas. I'm overdrawing this, of course, but you have to exaggerate in order to make a point. I am indicating a danger that we must try to avoid — the danger of isolation. After the doctor becomes a practitioner, he is even in danger of being isolated from his fellow doctors if they belong to a different specialty. They have their own specialists' societies and I would suggest that you read in *The Lancet* for October 18th, 1952, a paper by Sir Harold Himsworth entitled "Specialization, Stratification and Research". There is in it some very sound advice about the dangers of specialization. He recognizes the necessity of specialization but deplores its crystallization and stratification and points out that, after all, specialists get entrenched in their special skill and then the skill may no longer be necessary because medicine has advanced.

First Canadian Clinic for Drug Addicts Opened

Canada's first clinic for drug addicts was opened officially at the Mimico Reformatory, Toronto, Ont., in January — latest step in the Department of Reform Institutions' (Ontario) "five-year plan" aimed at rehabilitation of offenders of all types. The clinic has accommodation for 25 patients, who will be accepted on a voluntary basis only. It is considered a pilot unit, capable of expansion when and if the need arises; for administrative purposes it is combined with the A. C. Brown Memorial Clinic for Alcoholics, which is also on the premises.

The new centre is under the direction of Dr. R. G. Bell, Toronto specialist in alchoholism, and Dr. F. H. Van Nostrand, director of neurology and psychiatry for the Department of Reform Institutions. Establishment of the clinic followed a recommendation from a Senate committee in Ottawa that all provinces set up treatment centres for drug addicts.

World Health Day

April 7th is now celebrated around the world as World Health Day. It offers an opportunity to arouse popular interest in health needs and to stimulate the people's participation in the work of improving health. This year's World Health Day theme, "Destroy Disease-carrying Insects!", focuses attention on one of the most daring tasks ever undertaken in the field of public health — eradication of malaria by a relentless war against all insect-borne diseases.

There are 74 Outpost Hospitals and Nursing Stations operated by the Canadian Red Cross in Canada's remote areas.

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Changing Health Problems

(Continued from page 52)

lion days of disability a year, and over 50 million days of any illness.

Similarly, this aging of the population accounts for about 2 million of the days spent in hospital and for over a million doctors' home and office calls.

According to the estimates we have now, some 400,000 people are incapacitated on any given day, apart from those residing more or less permanently in institutions. Due to the population changes, particularly the mere increase in numbers, that figure would have been only a little more than one-third in 1901 and it will have increased by more than half in about fifteen years' time.

This means, in terms of volume of illness over a year, that today we have about 100 million more days of disability per year among Canadians than we might have had 50 years ago. Similarly, in another fifteen years from now we must expect another 100 million days added to that figure: very sizeable changes indeed, bearing in mind that in 1951 the estimated number of disability days was some 160 million per year.

This does not mean that our health is deteriorating. In fact, we have assumed that sickness rates have remained, by and large, stationary. A glance at the death rates over the past ten years reveals the same picture. The death rate has dropped for all age groups, particularly for the first years of life. The over-all death rate has been reduced by about ten per cent — certainly a big improvement in mortality — and yet there were about 11,000 more deaths in Canada in 1951 than there were in 1941.

This increased volume of morbidity and mortality indicates the need for the expansion of health services. Working in the same direction is the increasing rate of hospitalization. About 50 per cent of all deaths occurred in institutions in 1951, compared with 40 per cent in 1941. Taking into account both the greater number of deaths and the higher hospitalization rate, the demand on hospitals resulting from fatal illness has increased by 35 per cent over the past ten years apart from the fact that terminal illness is likely to be of longer duration today than it used to be.

Not only on leaving this world but also when we enter it, do we make use of doctors, nurses, and hospitals. While confinements and the care of the newborn cannot be classified as a result of ill health, they nevertheless require very much the same kind of services as does illness. In this respect they too constitute part of our health problem. During the period from 1941 to 1951, the birth rate went from 22 to 27 per 1,000 population. The number of births per year rose in the same period from some 250,000 to some 380,000 resulting in 130,000 more births in 1951 than there were in 1941. Here again it is not only the growing number that makes for a greater demand on health services but also the fact that the standard of service has increased. Of the births in 1941, only 49 per cent occurred in hospitals; of the larger number of births in 1951, almost 80 per cent were hospitalized. This means care for the mother as well as for the baby. Thus, these 130,000 confinements in 1951 may be assumed to have accounted for close to 10 per cent of all patient-hospital days in that year. The prospect for the future is an increasing number of births if the rate remains on the same or even on a somewhat reduced level. In the planning for health services the number of births and young children is an important factor because children under 15 account for about one-fifth of physicians' calls outside the hospital and

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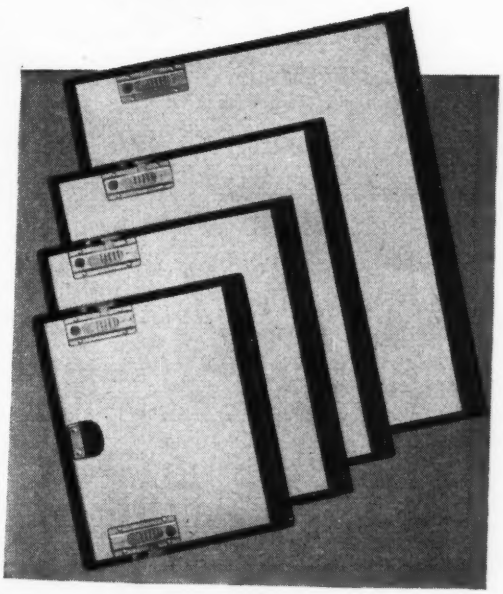

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Changing Health Problems

(Concluded from page 90)

for almost one-fifth of all hospital days.

If our population continues to increase according to the forecasts, it will mean that in fifteen years from now Canadian doctors will have to visit 11 million patients at their home instead of 7 million today; and they will have to see 25 million patients at their office instead of the 16 million they are seeing today. If we are to maintain the same population-physician ratio as we have today, the increased population in fifteen years' time will require about 7,000 more doctors. Correspondingly, we will require something like 35,000 more beds in public hospitals apart from tuberculosis and mental institutions. The visits to dentists would increase by about 700,000; and we would need about half as many dentists again as we have today. The same applies, of course, to nurses, and all other health personnel and facilities.

These are some of the foreseeable and measurable implications of a changing population. Health, however, is a many splendoured thing; there are many facets to it and, as mentioned before, there are many other powerful forces at work which will have their impact on the nation's health and health services in the years to come.

Penicillin Plant Completed in India

The first penicillin plant in southeast Asia has been completed in Pimpri, Bombay, by the Government of India with assistance from the United Nations. The plant is valued at $3,000,000.

All products of the plant are for use in India, with priority to be given to public health projects. Some will be used to give free treatment to children and mothers for yaws, syphilis, and other ailments. The new plant's products will benefit millions every year. With one 10-cc vial of penicillin four children can be treated for yaws, a disfiguring and crippling disease of the tropics.

The plant produced its first tank of penicillin in March 1955 and released its products last October. It took some four years of planning, recruitment of personnel, training, engineering, building, installation of equipment, and testing, before the first tank of penicillin was made.

He Says It with Flowers

J. W. Hughes, Kelowna, B.C., Rotarian, has probably given away more flowers than any other man in Canada. Since 1948 Mr. Hughes, a flower grower on a big scale, has been donating flowers to hospital patients and shut-ins through Rotary Clubs all over western Canada. In the past year he has donated a total of 110,000 blossoms to various old people's homes, hospitals, orphanages, schools for the mentally deficient, and persons confined to their own homes because of long illnesses. In preparation for next year's shipments, Mr. Hughes has already planted some 100,000 tulips at his lakeside ranch.

Grants on Monthly Basis

As a result of a resolution passed at the Ontario Hospital Association's last convention, the Ontario Department of Health has decided to pay the regular maintenance grants to hospitals on a monthly rather than a quarterly basis. Purpose of the change-over is to assist hospitals in reducing interest on bank overdrafts.

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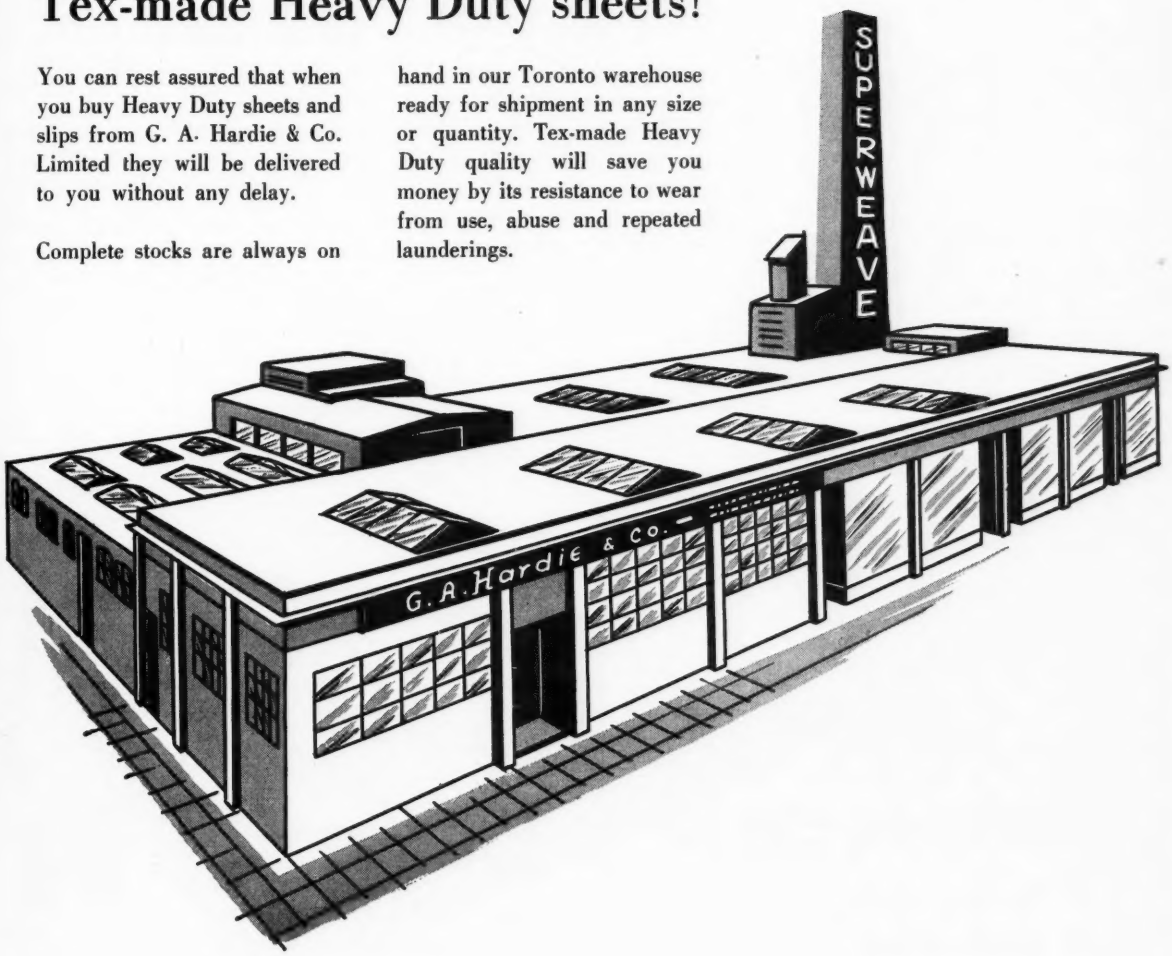

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Clinical Investigation

(Continued from page 38)

ideal focal point for doing clinical investigation. It is, I think, generally a better one than an institute for the study of a special subject. The word "institute" is used in many different ways. I do not necessarily mean an institute of medical research in which you have a number of laboratories, but rather an institute of a special clinical subject which is geographically separate from the main hospital. This tends to produce separate interests, although it may increase penetration in depth and in certain older centres it certainly has done a great deal to assist and to advance medical knowledge. I think, however, that University Hospital can provide an admirable place for the carrying out of clinical investigation because one has the benefit of one's colleagues' advice and help, and because one cannot know everything about everything.

It is very necessary for a good deal of clinical investigation, though by no means all, that the patients be in bed. If you are going to do careful metabolic studies, if you are going to do repeated respiratory function studies, if you are going to do studies of various sorts where careful control of diet or other factors may be involved then you have to have the patient in bed and preferably in a special place in the hospital where these factors can be controlled. I have been trying for 24 years to have a complete 24-hour specimen of urine collected on the general wards and I have as yet to succeed in getting it. So it is necessary for those particular purposes that the patient be in a special ward. That does not mean that clinical investigation cannot be done on general wards and on general service. It can — it depends on what kind you want to do. Similarly, you can do excellent clinical investigation with the patient not admitted to hospital at all. If you are going to do a long-term study, let me point out that when you admit the patient to a hospital bed you are changing the environment of that patient and although your observations may be extremely accurate, you may in point of fact not be observing what the patient's ordinary condition is at all. By the very admission of that patient you have altered psychological, social, and other reactions to his disease. Consequently, it is very desirable that you use the University Hospital as an investigative centre and extend it still further in terms of observation by the patient's own doctor, though in an area geographically removed. It is only thus, I think, that one can do really long-term observations without interfering with a patient's life to such an extent that it becomes impractical.

I mentioned earlier the need for conversational interplay. This, of course can be carried too far, for it is vital that people have time to do their own work and to think and consider by themselves. There are, perhaps, too many distractions: committee meetings, forms to be signed, and forms to be made out for other people to sign. We suffer, at least partly, from con-form-ism in more than one sense of that word. Yet in a university hospital such as this it is desirable and necessary that channels of communication be kept open. It is also highly desirable that non-professional staff be made to feel interested in and a part of the investigative team. Only thus can one really get an adequate and complete picture.

There is always, of course, a problem of the attitude of the scientific medical, and this is well illustrated by the accompanying poem (see page 38). There is no higher proportion of people in scientific medicine who have

that arrogant attitude than there is in any other group of people. Some people are that way no matter what group they are in. There is also a problem of attitude *towards* those engaged in scientific investigation. Many people think it is something so easy that they could do it if they wished. Actually it is very difficult. One thing which makes it so — although one does not complain of this — is that the patient always wants to go home just the day you don't want him to. That, of course, is common and it is very nice that he does want to go home and is able to do so.

Financial difficulties are also to be overcome. For instance, there is the patient you wish to keep in hospital longer than he might otherwise stay. Also, for the purposes of clinical investigation it is sometimes necessary to admit to hospital normal control subjects, and this means financial provision for their admission.

I have mentioned a number of problems concerning clinical investigation in a university hospital. There are others equally difficult and yet, as long as goodwill exists between the parties concerned, these can be met and overcome. In your University Hospital you have a great advantage in that it has youth and understanding and, consequently, a group of people who are relatively untrammeled by the traditions which sometimes hamper older universities and hospitals. If the atmosphere between the various departments is suitable, you have the opportunity and capacity for doing great work. Isolation need not be a drawback and it can be an advantage. The time which might be spent on the elevated railway rushing from one meeting to another can be the time spent in doing worth-while work. Above all, you can have, within your own group, the catalytic agents of wonder and conversational interplay so necessary for advance.

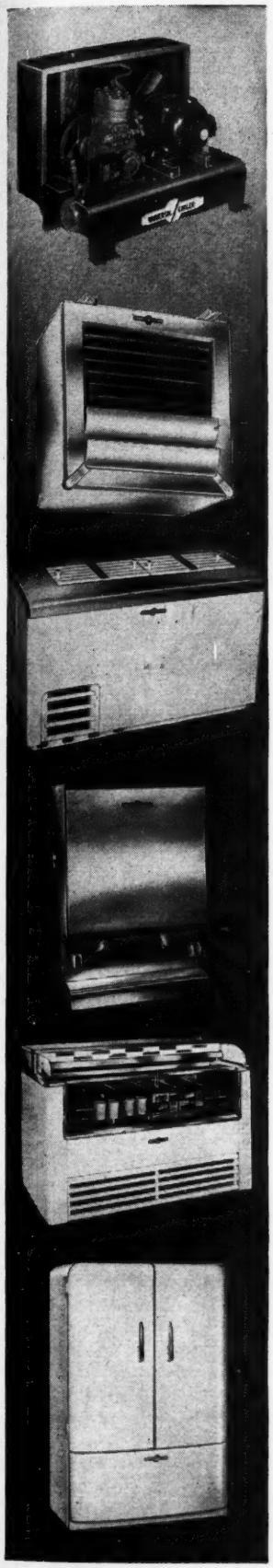
For Hospital Purchasing Agents

The 33rd *Hospital Purchasing File*, 1956 edition, is now available to hospital purchasing agents and others interested in this handy index. It is published by Purchasing Files, Inc., 919 North Michigan Ave., Chicago 11, Ill. A special reference section included in this edition is "Planning the Equipment for a New General Hospital" by Guy H. Trimble of the Division of Hospital and Medical Facilities, Public Health Service, Department of Health, Education, and Welfare. For material on many hospital departments, past editions of the file should be consulted.

"Tea"

Of interest to tea-drinkers will be a recently published work entitled *Tea—A Symposium on the Pharmacology and the Physiologic and Psychologic Effects of Tea.* Edited by Henry J. Klaunberg and presented at a conference at the New York Academy of Sciences held in May of last year, this interesting little monograph is not as esoteric as it may sound to the uninitiated. We quote:

" . . . there is not in human history a beverage about which there has developed so much of graceful ceremony and gracious, cultivated enjoyment of living as about tea . . . Tea is a social drink in the best sense of the word. It does not bring about a primitivizing or animalizing of the human being, but rather it cerebrates man at his human best with his most distinctively human structure, his cerebral cortex, 'hitting on all cylinders,' his discrimination enhanced, and his associations enriched."



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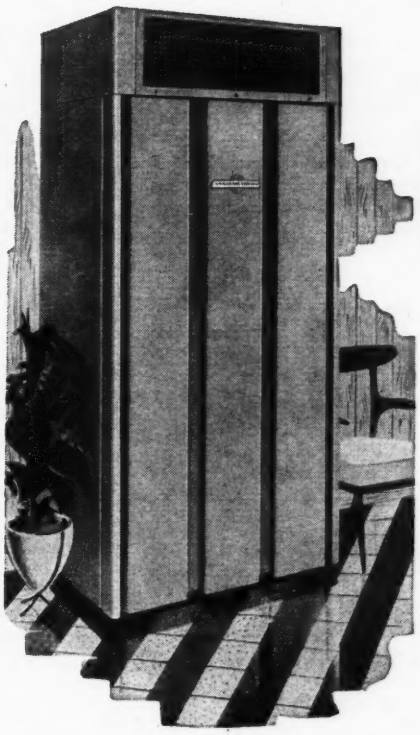

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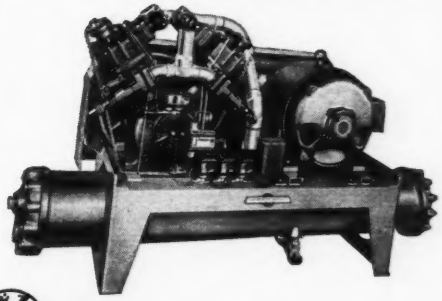

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A philosopher compares life to a piece of embroidery, of which, during the first half of his life, a man gets a sight of the right side, and during the second half, of the wrong side. The wrong side is not so pretty as the right, but it is more instructive: it shows the way in which the threads have been worked together.

Only when we look back at the long course of our life and its general result can we see the why and wherefore of it all. A thousand things become clear which were formerly obscure, and we gain a satisfying feeling of difficulties overcome.

With advancing age we receive unexpected rewards and compensations. We escape slavery to convention; we detect the superficial things and pay attention to the significant; we enjoy being patient; we have out-grown our keenest acrimonies; we are free of uneasy craving; we are no longer pompous and self-regarding; we have a feeling of immense relief from the number of dangers we have escaped; we have advanced from what was promised to what is fulfilled.

This is not to say that we must rest on our oars. A 1955 survey reported in *Industry* reveals that 64 per cent of the world's great achievements have been accomplished by men who have passed their 60th birthday. Between 60 and 70 years of age, 35 per cent of the world's great achievements were accomplished; 23 per cent between 70 and 80, and 8 per cent after 80.

Sir William Van Horne, builder of the Canadian Pacific Railway, said no man comes to the sub-conscious coordination of details necessary to control a vast system until he is 60. And if we forsake the mundane things of business to seek a lesson in knight errantry, we find that when the first lances of all Christendom were Chandos of England and Du Gueselin of France, John Chandos was over 70 and blind in one eye. Retiring and softspoken he was, but when the earth stirred to a slow thunder of armies the most dreaded device on a shield was still the red pile of Chandos. — *The Royal Bank of Canada Monthly Letter, December, 1955.*

"Open Door" Policy Pays Off

According to Dr. D. Ewen Cameron, director of the Royal Victoria Hospital's Allan Memorial Institute of Psychiatry, Montreal, an "open door" policy (under which the patients are free to leave if they choose) at the institute has been successful. Criminals or violently disturbed patients are not, of course, treated in this way, but those with milder disorders have reacted very favourably to the method. Dr. Cameron feels that patients who see barred windows and protected lights understand that they are expected to act violently, whereas, under the new system, their therapy is speeded up because they realize their submission to treatment is strictly voluntary.

Let Us Be Vigilant

Let us, by all means, do everything we can to bring rehabilitation forces to bear on the individual as soon as it is known that a disabling condition exists. But let us go further than this. Let us in all daily living be vigilant. In all our activities or business operations, let us try to eliminate all causes that might contribute to accident disease or disability. In this way the whole problem will be kept to a minimum. — *Ian Campbell in "The Hearing Eye," Fall, 1955.*

Book Reviews

(Concluded from page 56)

personnel. Hospital engineers, too, feel that others in the hospital plant do not fully comprehend their working problems. And hospital administrators repeatedly stress this need for understanding by physicians, hospital personnel and their board, not only of the administrator's immediate problems but fundamentally of the whole operation of the hospital. Finally, all in the hospital field continually talk about the need for public knowledge of the complexities of hospital administration.

To reach the core of such needed knowledge, the study staff from Cornell has spent many man hours in each department of the hospital, talking to the individual hospital employee at all levels and to board members and physicians. With this broad range of information they have written a report which gives all of those concerned in any way with the hospital a clear conception of what it is like to work there and what some of the problems are that confront those involved with hospital service.

Thus, this book will certainly enlighten everyone who reads it, whether the reader is an experienced hospital administrator or the newest member of the women's hospital auxiliary. It should be broadly read by laymen interested in the hospital, by hospital board members and staff and physicians. The net result will be greater co-operation among all the groups concerned with care of the patient.

Certainly this study report becomes an important teaching resource for all the schools which prepare people for work in the hospital — schools of medicine, nursing, hospital administration and other paramedical specialties. It should also be valuable in the schools of public health and for other groups, such as Blue Cross Plans, having programs related to the hospital.

This report, obviously, can offer no quick solution to better hospital operation. But it does point toward refinements in our working together to improve the care of sick people. It is a volume which the hospital field has awaited for a long, long time. — *George Bugbee. Reprinted through the courtesy of "Hospitals", December 1955.*

"Labtec Cook Book" Available

Recently a group of medical laboratory technologists in Saskatoon, Sask., collected the favourite recipes of their co-workers throughout Canada and compiled *The Labtec Cook Book*. Published by the Canadian Society of Laboratory Technologists, this interesting, compact cook book contains approximately 425 tested recipes. Since so many laboratory technologists are homemakers as well as career girls, the book contains many recipes designed for quick preparation.

One of the purposes in publishing the cook book was to publicize the field of medical laboratory technology and thus attract prospective students to a career with a rapidly expanding future. Some of the funds raised by the sale of the book will be used to cover expenses connected with the First North American Conference of Medical Laboratory Technologists, to be held in Quebec City, in June. Copies of *The Labtec Cook Book* are available through the national office of the Canadian Society of Laboratory Technologists, 61 Victoria Ave., N., Hamilton, Ont., at the price of $1.00 per copy.

An Oriental saying: He whose science exceedeth his sense, perisheth by his ignorance.

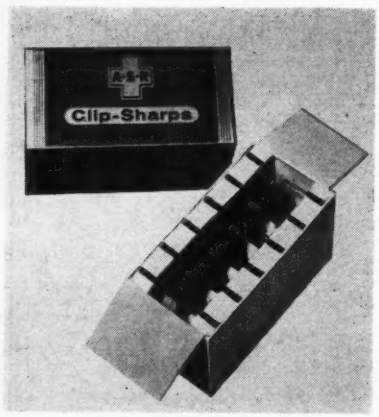
News Released by Hospital Supply Houses

By C.A.E.

New Package For Surgical Blades

A new convenient and economical method for packing surgical blades that completely eliminates the need for handling individually wrapped blades has been introduced by the American Safety Razor Corp.

Called "Clip-Sharps," each box contains one gross of ASR surgical blades in units of 24 unwrapped blades per clip. The required number of blades, one to 24, can be removed easily from the clip and placed onto a rack arm, which then is inserted into the sterlizing solution.



"Clip-Sharps" it is claimed, provide a quick, easy, and low-cost way of using a small or large number of blades without the time and cost involved with individually wrapped blades.

There are six clips per box, protected by rust inhibiting paper. Any sterilizing rack and any reliable, non-corrosive sterilizing agent may be used.

Surgical Glove Sterilization Chart

Proper care and cleaning of surgical gloves can result in a considerable saving to any hospital. Keenly aware of this fact is the Pioneer Rubber Company, Willard, Ohio, which has just compiled a handy 5½ by 11¼ inch chart entitled "How To Sterilize Surgical Gloves."

Besides helping hospitals save money, the company's purpose in producing the chart is to assist hospital personnel in establishing correct surgical glove handling techniques. The information incorporated in the chart is based on Pioneer's 35 years of experience in the design and production of surgical gloves.

Copies of the chart can be obtained by writing to the Pioneer Rubber Company, Surgical Division, Willard, Ohio, or their Canadian distributors, Fisher and Burpe Limited, Toronto, Winnipeg, Edmonton, or Vancouver.

Appointment by Smith and Nephew

Mr. G. W. Walker, sales director of Smith and Nephew Limited, Montreal, has announced the appointment of James G. Lynch as drug trade and medical service representative in the Province of British Columbia, Mr.

James G. Lynch

Lynch will augment the sales force in British Columbia in the company's program of expansion.

Sales Manager At Air-Shields

John E. Addy has been appointed sales manager of Air-Shields, Inc., maker of the Isolette infant incubator, it was announced by Samuel Y. Gibbon, president of the firm. Mr. Addy has been with Air-Shields four and a half years and was formerly assistant sales manager.

Appointment At General Steel Wares

The appointment of Richard Gaunt as general manager of the Commerical Kitchen Equipment Division of General Steel Wares Limited, has been announced by W. F. Holding, president and managing director of the company.

Richard Gaunt

Mr. Gaunt, who has had wide experience in supplying commercial kitchen equipment to hospitals, hotels, restaurants, institutions and industrial organizations, will be responsible for all designing, engineering and manufacturing activities within the division.

New Infusion Set

Cutter Laboratories, Berkeley, California, has introduced a new pediatric scalp vein infusion set. Pyrogen free and sterilized both inside and out, this disposable scalp vein set is ready for immediate use. Packaged in a polyethylene envelope, it consists of: plastic female adapter; 12 inches of soft plastic tubing; and a short-beveled, small gauge needle in a protective sheath. With this set no head restraints are necessary and normal head movement is permitted by the slack in the coiled tubing. The flexible plastic tubing allows easy coiling and taping to the infant's scalp. Greater comfort is obtained and nursing care is minimized. Cut-downs are rarely necessary.

Automatic Pipesetting Device

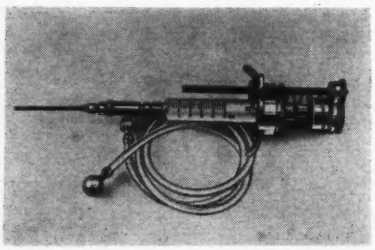
The Aupette, a new automatic pi-

(Continued on page 114)

ACROSS THE DESK

(Continued from page 112)

petting device, is now being manufactured by Clay-Adams, Inc. The instrument delivers predetermined quantities of liquid repeatedly, without resetting or remeasuring, and has many applications in clinical, industrial and chemical laboratories, or wherever a measured volume of fluid is to be dispensed repeatedly. It can also be used for mass inoculations of animals.



Through careful design and engineering of the Aupette, it accommodates standard size syringes. Either 10cc, 5cc or 1cc syringes may be used interchangeably in the same Aupette merely by using nylon adapters.

The instrument can be used with one hand and requires only slight thumb pressure and no special training. Plastic tubing, valve, metal tip and sinker are included with each instrument. These permit fluid to be drawn constantly from the source of supply so that filling a large number of tubes or vials can be accomplished with a minimum of time and effort.

The Aupette is sold through surgical and scientific supply dealers. Complete details are available from Clay-Adams, Inc., 141 East 25th Street, New York 10, N.Y.

Kirsch Vertical Traverse Blinds

An interesting innovation in window treatment has been introduced in Kirsch Vertical Traverse Blinds.

An excitingly different type of blind, Kirsch Verticals have all the advantages of deluxe "Venetians" with extra features all their own. Kirsch Verticals not only give smooth-operating, light-and-air control, and close for privacy, but also draw open—like draperies—to give windows a fresh fascinating beauty.

Kirsch Verticals are ideal for patients' rooms, public reception rooms, staff lounges and nurses' residences.

A descriptive folder is available from the makers, Kirsch Manufacturing Co. of Canada Limited, Woodstock, Ontario.

New Baxter Plant Planned

Purchase of seven acres of land at Alliston, Ontario, as the future site of Baxter Laboratories of Canada, Limited, was announced by Ralph Falk II, company vice president. Present operation is at Acton, Ontario.

Construction of a modern, efficient plant of 30,000 square feet will begin in the Spring. Transfer of operations from Acton to the new plant will be completed by the end of the year, Mr. Falk estimated. The plant will employ 75 to 100 people.

The new building is being designed by Gordon S. Adamson of Toronto.

Flame Photometer Bulletin

The new Coleman flame photometer for rapid and accurate determination of sodium, potassium and calcium, is described in a new eight-page bulletin. Of importance to hospitals and clinical laboratories, the new flame photometer combines safety, ease of use, reliability, precision and economy. For this bulletin write to Canadian Laboratory Supplies Limited, 3701 Dundas St. West, Toronto 9. Ask for bulletin 231A.

Lily Paper Service

Lily Cups Limited, with their complete hospital paper service in matching green leaf design, claim to have the answer to many of the food service problems facing the modern hospital today.

They state that paper service, because of its single service feature, offers the dietitian a fast, efficient, convenient and economical service. It answers all problems by speeding up the entire food service cycle, thus enabling the staff to serve all patients in less time.

Single service is particularly applicable to isolation wards where the possibility of cross-contagion is completely erased.

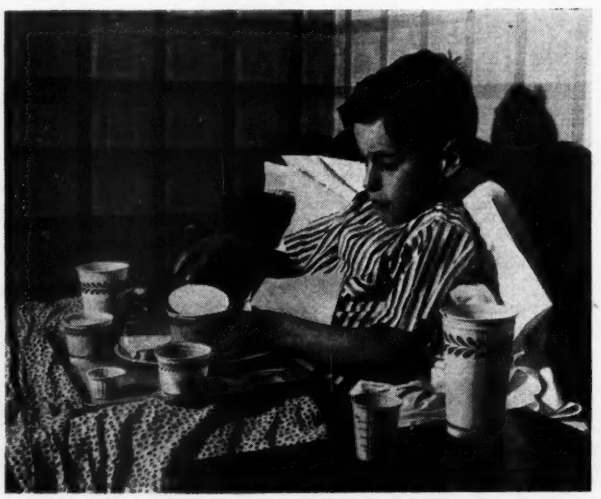
Formerly, patients in rooms close to serving kitchens had to listen to the din and clatter of dishes when meals were being prepared and served, and when dishes were being returned, washed and restacked. However, with single service, the quietness with which meals are served is appreciated by patients and employees alike. This provides a more cheerful atmosphere.

There is unlimited convenience to paper service because it eliminates the time and effort in bussing, scraping, stacking, washing, sterilizing and restacking of crockery and glassware. Quite often dishwashers and kitchen help can be eliminated or redistributed to better advantage in preparing or serving meals. Also in most cases, considerable savings result because, with no dishwashing, the largest single item of expense — breakage —is eliminated.

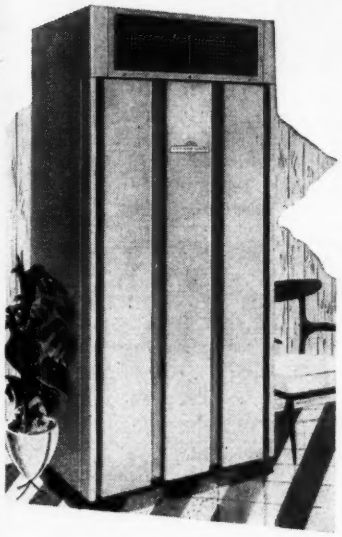
The space-saving features of paper service make it possible to store a large quantity of cups in a very small space in the main kitchen, secondary kitchens, and on the electrically-heated carts. Supplies are drawn weekly from the main store room, thereby enabling the head dietitian to keep an ample supply on hand at all times and also to have an accurate method of cost control.

In the medical department, paper cups and containers have a wide variety of uses for medicines, pills, capsules, oils; as well as laboratory use for specimens, dusting powders, ice cubes and dressings.

Further information on Lily Matched Paper Service may be obtained by writing to Lily Cups Limited, 300 Danforth Road, Toronto 13, Ontario.



Cabinet Air-Conditioner



Illustrated above is the new air-conditioning cabinet now being shown by Universal Cooler Company, manufacturers of commercial refrigeration equipment. This cabinet, suitable for installation in hospitals, offices, and restaurants is a big-capacity cabinet which provides comfort cooling at its best. It occupies small floor space. It is attractive in appearance and can be obtained in a choice of four colours or in colour combinations to blend with the decorative scheme of the room in which it is installed. For further information write the Universal Cooler Co. Limited, Brantford, Ont.

New X-Ray Apparatus

"Blackboard x-ray" — a new type of x-ray apparatus that employs dry metal plates, which can be wiped off and re-used, has been announced by the General Electric X-Ray Corp.

Since the new method of making x-rays is entirely independent of water or chemical supplies and electrical power, it is ideal for use in the event of civil disaster.

Field-tested for civilian defense at Albany Medical College, Albany, N.Y., under Dr. John F. Roach, radiologist, the apparatus is still being perfected for commercial sale and no price has been established for this purpose.

Employing a new process termed "xeroradiography" (pronounced "zero-radiography"), the new equipment makes it possible to view a fully-developed x-ray picture in only 40 seconds and to eliminate many of the problems now involved in stockpiling and storing x-ray film.

Xeroradiography utilizes a conventional x-ray source, but produces an image on a selenium-coated aluminum plate.

One great advantage of the fact that the image can be "erased" and reused is that it is thus necessary to stockpile relatively few plates. Another advantage of xeroradiography is that while the plate may be exposed by radiation after an atomic blast, it is not permanently changed, and thus will not be spoiled as might conventional film unless it is shielded in costly lead containers. Operation of the equipment is made independent of electrical power through the use of a gasoline-driven generator.

Still another advantage is that, since there is no wet-developing procedure, one is not dependent upon a supply of uncontaminated water, nor on the availability of special chemicals. These factors combine to make xeroradiography ideally suited for civil defence.

Development of xeroradiography does not mean that conventional x-ray film is by any means obsolete. It merely means that owners of present x-ray machines may now produce radiographic images either on film or on re-usable xeroradiographic plates, choosing whichever method best suits each task.

The image produced has a bas-relief or three-dimensional appearance, and in some cases detail is revealed that is rarely visible on film without special accessories or carefully-controlled technique.

HOW XERORADIOGRAPHY WORKS: The selenium-coated metal plate is electrostatically charged before exposure to x-rays. The x-rays, which pass through an arm or leg will discharge the plate partially, in inverse proportion to the density of the x-rayed object. The result is a latent electrostatic image on the plate. To make this pattern visible, one simply inserts the plate in a device which sprays it with a powder. This powder adheres to the charged parts of the plate (like iron filings to a magnet), gathering more closely in the heavily charged areas than in the lightly-charged areas, thus forming a visible image.

The equipment needed for xeroradiographic work includes plates, size 1 foot by 1½ feet, a sensitizing or charging device, a developing chamber, transferring equipment to obtain a permanent record if desired, viewing equipment, and facilities for cleaning the plates. These could all be put into a single box no larger than a desk.

The x-ray equipment used for xeroradiography is the same as for conventional film. In quantity production, the cost of producing a xeroradiographic image on a plate (i.e., processing cost, excluding investment in equipment), is estimated at around 50 per cent less than for film.

Warns of Static Electricity in O.R.

An entirely new and streamlined Staticator (R) designed especially for use in hospital operating rooms has been announced. This new unit provides both audible and visual warnings whenever static electricity is present anywhere in the operating room.

The new hospital Staticator comes as a complete package unit that includes all equipment and accessories necessary to protect any size hospital operating room against unsuspected static hazards. Everything necessary for quick and easy installation is included in the complete package unit.

Use of these new hospital units in operating room areas, it is claimed, will reduce to a minimum any chance that an unsuspected static condition may cause an explosion or fire in the protected area.

For full information write Powerlite Devices Ltd., 1870 Davenport Rd., Toronto.

Webb Appointed by Stevens Companies

Norman Webb

Mr. E. J. Turner, sales manager of The Stevens Companies, has announced the appointment of Norman Webb as the company's representative in the Province of Nova Scotia.

Mr. Webb is widely known to hospital personnel, having served three years at No. 14 General Hospital from Montreal and three years at No. 7 General Hospital from the Maritimes, during the last war.

Upon returning to civilian life, Mr. Webb was employed with an organization selling and servicing X-Ray equipment in the Maritimes. He has had considerable experience with many problems relating to the Institutional field.

Index of Advertisers

MARCH, 1956

Authorized as Second Class Mail, Post Office Department, Ottawa. The Canadian Hospital is published by The Canadian Hospital Association, 57 Bloor Street West, Toronto 5.